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ABSTRACT

This report of a congressional hearing presents information on children exposed to drugs prenatally and their later educational problems. The document begins with an opening statement and a prepared statement from Representative Charles B. Rangel. Testimony and prepared statements from the following witnesses are included: (1) Evelyn Davis, Assistant Professor of Pediatrics, Department of Pediatrics and Department of Child and Adolescent Psychiatry, Harlem Hospital Center; (2) Charlie Knight, Superintendent, Ravenswood City School District, East Palo Alto, California; (3) Diane Powell, Director, Project DAISY, District of Columbia Public Schools; (4) P. Michael Timpane, President, Teachers College, Columbia University, New York, New York; (5) Robert Chase, Vice President, National Education Association; (6) Elaine M. Johnson, Director, Office for Substance Abuse Prevention, Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, Department of Health and Human Services; and (7) Beny J. Primm, Associate Administrator for Treatment Improvement, Alcohol, Drug Abuse, and Mental Health Administration, Public Health Service, Department of Health and Human Services. The appendix includes a statement by Representative Jim Ramstad on the problems of drug-exposed children. (ABL)

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DRUG-EXPOSED KIDS: A CRISIS IN AMERICA'S SCHOOLS

ED339936

HEARING

BEFORE THE

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

SEPTEMBER 13, 1991

Printed for the use of the
Select Committee on Narcotics Abuse and Control

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HEARING ON DRUG-EXPOSED KIDS: A CRISIS IN AMERICA'S SCHOOLS

FRIDAY, SEPTEMBER 13, 1991

U.S. House of Representatives,
Select Committee on Narcotics Abuse and Control,
Washington, DC.

The select committee met, pursuant to call, at 9:40 a.m., in room 1100, Longworth House Office Building, Hon. Charles B. Rangel (chairman of the select committee), presiding.

Members present: Representatives Charles B. Rangel, chairman, and Bill Paxon.

Staff present: Edward H. Jurith, staff director; Peter J. Coniglio, minority staff director; James Alexander, press secretary; Jennifer Ann Brophy, professional staff; George R. Gilbert, staff counsel; David Goodfriend, staff assistant; Michael J. Kelley, staff counsel; Marianne Koepf, staff assistant; Steve Skardon, professional staff; Mary Frances Valentino, minority staff assistant, and Melanie T. Young, minority professional staff.

OPENING STATEMENT OF HON. CHARLES B. RANGEL, CHAIRMAN

Mr. Rangel. Good morning and welcome to the hearing that's being held by the Select Narcotics Committee. I am the chairman of the House Select Narcotics Committee. This hearing is being held in the Ways and Means hearing room. I'm three seats away from the chairmanship of that committee so I just hope that no one goes back home, especially to Chicago, saying that I was chairing the Ways and Means hearing. It doesn't go over big down here where chairmen fear ambitious people taking their seat.

In any event, we're going to have a good discussion this morning. We're not going home with answers to the serious problems that are going to be discussed. But you should know that the most knowledgeable people in this particular field will be here with us today, giving presentations, having exchanges, and within the time limits that are left to us, answering some of the questions that you may have.

We have rhetorically and politically talked about a war against drugs. And yet, if you think of everything that is necessary in order to be effective in any war, you include having someone that is as well-known as Colin Powell, who certainly earned the respect of the Nation and, indeed, the free world, as the coordinator of a war.

We haven't enjoyed that luxury in this so-called war. When we were in the Persian Gulf, there was always someone there to share with the American people exactly what was going on. We have not been that fortunate in this so-called war.

So if we were to talk about law enforcement, no one here on this panel or in the audience could really lay out the strategy that we have, except putting people in jail. And that's not working.

No one would say what programs we have in rehabilitating drug addicts. Or more important, what are we doing to keep people out of jail? A very, very costly operation.

If we were to talk about foreign policy, no one in this audience could say exactly what we're doing in drug-producing countries. We know that 90 percent of the coca leaf that's converted to cocaine is coming from Peru. But today we don't know what the strategy is to eradicate these drugs.

If we were to talk about treatment—if one of my own children or grandchildren was addicted to drugs and they were to come to me, and ask this chairman of the committee, what do you do? Where do you go? What modality? Nobody in the Congress or in the country could do anything except guess.

So until we are prepared to recognize that this is not going to be an easy victory, we'd have to concentrate on what we can do to prevent people from becoming dependent on drugs and alcohol in the first place. That issue is not even on the scope.

The question of the homelessness, the joblessness, the despair, the poverty, the disease, the health crisis, and the hopelessness, unfortunately, is not on the Republican or Democratic agenda.

I might even go so far as to say that it's not even on the Nation's spiritual agenda. Because I cannot think of anything that is more moral, or more spiritual, or more miraculous, or more Godly, than the birth of a child. The whole concept of Christmas is based on the birth of a child.

And today we'll see that children are being born today, abandoned by their parents, picked up and sometimes nurtured and loved by people who don't even know who they are—nurses and doctors—some born with the pain and infliction of drug addiction, others with AIDS. The most precious commodity that we have as civilized human beings being ignored. And as these drug-exposed children go through the very expensive process of health care, they are now moving on into the educational system.

And here the greatest Nation in the world, with communism falling down all around, we find ourselves in a very negative economic budgetary situation and also in a trade deficit; we find that we have not been as successful or competitive as an industrialized nation should be.

In this very room we hear from economists, business people, sharing with us what we have to do to be competitive and to meet the labor needs of 2000 and after.

And yet, the question of whether we're doing a job in our schools, in our hospitals, in a drug-free community, is never on the agenda. It's raised; it's responded to in a positive way. But that is all.

Today we know that it is possible to do something for drug-exposed children. Obviously, if we ignore the problem morally, we can't run away from our problem fiscally—legally, the children have to be educated. We know that an effort has to be made before the child is born to educate the mother as to what she is doing to her baby if she continues to abuse drugs.

Certainly we have to ask, and I think it's easy enough to do, whether or not the children are coming from a particular community. Is the community in economic distress? Is there a problem of joblessness and homelessness? Does it contribute to dependency of drugs?

And if recent reports are accurate—and we know they are—then certainly we should try to remove the problems that are causing the dependency.

We've had a hearing on this matter before, in this very same Congress. And we have found that the Administration said that this falls under the Individuals With Disabilities Education Act, and the Governors should determine whether these children are eligible for rehabilitative services. That's sad.

We see this Government saying that, it's not our problem; it's going to be the Governor's problem, and we'll just throw these children in a disabled category.

We'll hear from teachers who don't seem to be screaming out for help. Teachers, like politicians, seem to feel so secure in their profession that they don't know how to collectively ask for help. But I think these children are going to give them a challenge that will force them to scream out for help.

Today we're going to begin a process, as part of the 21st Congressional Black Caucus weekend, to see what we can learn and take back to our schools, our churches, our homes, and our communities so that we can make some contribution to the resolution of this problem for ourselves, our families, our communities, for the Nation and, indeed, the world.

[The statement of Mr. Rangel follows:]

OPENING STATEMENT
OF
THE HONORABLE CHARLES B. RANGEL
CHAIRMAN
HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

"DRUG-EXPOSED KIDS: A CRISIS IN AMERICA'S SCHOOLS"

SEPTEMBER 13, 1991
9:30 A.M.
ROOM 1100 LONGWORTH HOUSE OFFICE BUILDING

A FEW DAYS AGO, SCHOOLS ACROSS THE NATION OPENED THEIR DOORS AND BEGAN A NEW YEAR. MANY CHILDREN STARTED SCHOOL FOR THE FIRST TIME. THOUSANDS OF OUR NEW STUDENTS SUFFER FROM DISABILITIES DUE TO THEIR MOTHERS' DRUG ABUSE DURING PREGNANCY. THIS YEAR, OUR NATION'S EDUCATION SYSTEM WILL SEE MORE DRUG-EXPOSED CHILDREN THAN EVER BEFORE. WE HAVE A CRISIS ON OUR HANDS.

TODAY, THE SELECT COMMITTEE HOLDS ITS SECOND HEARING ABOUT DRUG-EXPOSED CHILDREN IN THE SCHOOLS. AT OUR LAST HEARING, WE LEARNED THAT TEACHERS ACROSS THE NATION ARE WITNESSING MORE CHILDREN WITH UNUSUAL BEHAVIORAL DISABILITIES OFTEN DUE TO PRENATAL DRUG EXPOSURE. TEACHERS HAVE NO PLACE TO TURN: NO TRAINING ABOUT HOW TO WORK WITH DRUG-EXPOSED CHILDREN, NO READILY AVAILABLE INFORMATION ON THE SUBJECT, AND FEW, IF ANY, PROGRAMS TO WHICH THEY CAN REFER CHILDREN.

WE LEARNED THAT RESOURCES FOR SPECIAL EDUCATION PROGRAMS ARE INADEQUATE TO ACCOMMODATE THE LARGE NUMBERS OF DRUG-EXPOSED CHILDREN. SOME PROGRAMS EVEN EXCLUDE SUCH CHILDREN.

WE LEARNED THAT IT IS POSSIBLE TO REHABILITATE DRUG-EXPOSED CHILDREN AT AN EARLY AGE, PREVENTING COUNTLESS FUTURE HEALTH AND REMEDIAL EXPENDITURES. MAINSTREAM TEACHERS, GIVEN THE RIGHT TOOLS AND PROPER SUPPORT, CAN HELP PERFORM MUCH OF THIS REHABILITATION.

MANY WITNESSES TOLD US THAT ANY ATTEMPT TO SOLVE THIS PROBLEM MUST ENTAIL CURBING PREGNANT WOMEN'S DRUG ABUSE. PREGNANT WOMEN, WE WERE TOLD, OFTEN HAVE TROUBLE FINDING A DRUG TREATMENT.

PERHAPS MOST IMPORTANT, WE LEARNED THAT OUR NATION'S SCHOOLS ARE VIRTUALLY UNPREPARED FOR THE MASSIVE INFLUX OF DRUG-EXPOSED CHILDREN BEGINNING TO HIT THEM. IF WE WANT TO PREVENT THE DETERIORATION OF EVERY AMERICAN STUDENT'S EDUCATION, SOMETHING MUST CHANGE. WE NEED TO AGGRESSIVELY COMBAT THIS CRISIS.

THE DEPARTMENT OF EDUCATION TESTIFIED AT OUR FIRST HEARING THAT THEY WERE DOING EVERYTHING POSSIBLE TO ADDRESS THE PROBLEM OF

DRUG-EXPOSED CHILDREN IN THE SCHOOLS. THEY SAID THAT FEDERAL EARLY INTERVENTION PROGRAMS, WHICH CAN HELP THESE CHILDREN, ARE ADMINISTERED AND FUNDED PRIMARILY AT THE STATE LEVEL; THE FEDERAL GOVERNMENT, THEY SAID, CANNOT MANDATE HOW STATES SHOULD OPERATE THESE PROGRAMS. THE DEPARTMENT OF EDUCATION ALSO PROMISED THAT THEY WILL PROVIDE MORE INFORMATION FOR TEACHERS ABOUT DRUG-EXPOSED CHILDREN.

I AM NOT SATISFIED THAT WE ARE DOING EVERYTHING POSSIBLE TO HELP THIS POPULATION. AT TODAY'S HEARING, I WANT TO LEARN HOW THE DEPARTMENT OF HEALTH AND HUMAN RESOURCES IS ADDRESSING, OR INTENDS TO ADDRESS, THE PROBLEM OF DRUG-EXPOSED CHILDREN. WHERE SHOULD WE FOCUS OUR ATTENTION? HOW CAN THE DEPARTMENT OF HEALTH AND HUMAN RESOURCES WORK WITH THE DEPARTMENT OF EDUCATION? WHAT SHOULD BE CONGRESS'S ROLE?

TEACHERS NEED MORE ASSISTANCE. EARLY INTERVENTION PROGRAMS SHOULD BE MORE READILY AVAILABLE TO DRUG-EXPOSED CHILDREN. PREGNANT WOMEN SHOULD HAVE EASY ACCESS TO DRUG TREATMENT AND PRENATAL CARE. I BELIEVE

CONGRESS CAN HELP EXPAND CURRENT INFORMATION COLLECTION AND DISSEMINATION EFFORTS REGARDING DRUG-EXPOSED CHILDREN. WE CAN PROVIDE MORE TEACHER TRAINING. WE CAN EXPAND SPECIAL EDUCATION PROGRAMS THAT OFTEN DO NOT MANDATE INCLUSION OF DRUG-EXPOSED CHILDREN. AND WE CAN IMPROVE DRUG TREATMENT AND PRENATAL CARE FOR PREGNANT WOMEN.

AT OUR FIRST HEARING, TEACHERS TESTIFIED THAT THEY WANT HELP. TODAY, WE WILL HEAR FROM AN EDUCATORS' ORGANIZATION AND A TEACHERS' COLLEGE TO LEARN MORE ABOUT THE COLLECTIVE NEEDS OF EDUCATION PROFESSIONALS REGARDING THIS ISSUE. I AM CONFIDENT THAT ORGANIZATIONS SUCH AS THE ONES REPRESENTED TODAY WILL SHOW A STRONG COMMITMENT TO IMPROVING SUPPORT FOR TEACHERS.

OUR HEARING TODAY COINCIDES WITH THE CONGRESSIONAL BLACK CAUCUS LEGISLATIVE WEEKEND. THE ISSUE OF PRENATAL DRUG EXPOSURE IS IMPORTANT TO THE AFRICAN AMERICAN COMMUNITY. BUT IT IS NOT RESTRICTED TO THE AFRICAN AMERICAN COMMUNITY. THE RATE OF DRUG ABUSE AMONG PREGNANT WOMEN IS VIRTUALLY THE SAME ACROSS ALL RACIAL AND SOCIO-ECONOMIC

BOUNDARIES. DRUG-EXPOSED CHILDREN COME IN ALL COLORS. AND EVERY CHILD'S EDUCATION IS HARMED WHEN HIS OR HER TEACHER MUST SPEND TOO MUCH TIME TRYING TO CONTROL A FEW BEHAVIORALLY DISABLED CHILDREN IN THE CLASSROOM. SO EVEN THOUGH WE WILL DISCUSS WAYS IN WHICH THIS CRISIS AFFECTS AFRICAN AMERICANS, THIS PROBLEM IS BY NO MEANS ONE THAT AFFECTS ONLY AFRICAN AMERICANS AND OTHER MINORITIES.

I LOOK FORWARD TO OUR WITNESSES' TESTIMONY TODAY. WE ALL AGREE THAT THIS IS A CRITICAL ISSUE. NOW WE MUST FIND THE BEST WAY TO ATTACK IT.

Mr. RANGEL. We have an outstanding panel here, as I pointed out, that will be sharing their views with you. Then we hope that the panel will interact with each other so that we could discuss points raised, and then we'll ask the audience to join us.

Dr. Evelyn Davis is the assistant clinical professor of pediatrics, department of pediatrics and department of child and adolescent psychiatry, at my very own home hospital, Harlem Hospital Center. No one gives more and tries more than this department to do their job, and they go beyond that

The superintendent of Ravenswood City School District in East Palo Alto, CA, Dr. Charlie M. Knight, is with us.

Dr. Diane Powell, the director of Project DAISY, District of Columbia Public Schools.

From Columbia University, Mike Timpane, the president of Teachers College, who has been with us before.

From the education area, the vice president of the National Education Association, Bob Chase.

From the Administration, working closely with the Congress and the Select Narcotics Committee, Dr. Elaine Johnson, who is the director of the Office for Substance Abuse Prevention for the Department of Health and Human Services.

And, of course, Harlem's very own, Dr. Beny Primm, who, in addition to operating many programs for treatment, has now been appointed as the associate administrator for Treatment Improvement, the Department of Health and Human Services.

We've been joined by Bill Paxon, my colleague and friend from Buffalo, NY, and an outstanding member of the Select Narcotics Committee.

Dr. Davis, we will start with your testimony. And let me share with the panelists, that your prepared testimony will be entered into the record in its entirety, without objection of the committee. So even though you're free to read it, if you feel more comfortable in highlighting it, or referring to it, or adding to it, that is the decision that you will make.

We'll start with Dr. Davis. Thank you so much for being with us.

STATEMENTS OF EVELYN DAVIS, ASSISTANT CLINICAL PROFESSOR OF PEDIATRICS, DEPARTMENT OF PEDIATRICS AND DEPARTMENT OF CHILD AND ADOLESCENT PSYCHIATRY, HARLEM HOSPITAL CENTER; CHARLIE M. KNIGHT, SUPERINTENDENT, RAVENSWOOD CITY SCHOOL DISTRICT, EAST PALO ALTO, CA; DIANE E. POWELL, DIRECTOR, PROJECT DAISY, DISTRICT OF COLUMBIA PUBLIC SCHOOLS; P. MICHAEL TIMPANE, PRESIDENT, TEACHERS COLLEGE, COLUMBIA UNIVERSITY, NEW YORK, NY; ROBERT CHASE, VICE PRESIDENT, NATIONAL EDUCATION ASSOCIATION; ELAINE M. JOHNSON, DIRECTOR, OFFICE FOR SUBSTANCE ABUSE PREVENTION, ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND BENY J. PRIMM, ASSOCIATE ADMINISTRATOR FOR TREATMENT IMPROVEMENT; ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION, PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF EVELYN DAVIS

Dr. Davis. Thank you very much. I am absolutely delighted to be here to share some of my thoughts and some of my real concerns with all of you.

In a large minority community like Harlem, where poverty, inadequate education, lack of employment opportunities, histories of abuse and neglect, disenfranchisement, and a sense of hopelessness are the norm.

Cocaine and crack have taken their toll and in many instances destroyed the absolute fabric of family life as we know it.

Cocaine use, however, is widespread throughout our land. And I need to say this to an audience like ours because most of us see news stories about minorities using drugs and we absolutely pay little attention to what's happening in the real world.

Cocaine is used by all races and by all classes in this country and around the world, and we need to realize that this represents a national tragedy—not just for minority communities but for the Nation as a whole.

As an Afro-American pediatrician, working and living in Harlem and spending so much time in the departments of pediatrics, child-adolescent psychiatry, and rehab medicine, I feel I have perhaps some insight into what some of the issues are in this problem and also to give some insight as to how we can begin to attack the incredible assault on our society. I guess that's the way I have to look at it. We really are being assaulted by something that we've never had to meet before.

I've said before to many audiences that at Harlem we've seen efforts by drug lords to distribute drugs in schools and candy stores. They've given the drugs out free of charge so that youngsters can take them home to their parents. This is an absolute war that we're facing.

Cocaine is the No. 1 illicit drug of choice amongst pregnant women in the United States, with New York City registering a staggering twentyfold increase in maternal cocaine use during the past decade.

We at Harlem Hospital have been involved in a lot of informal research. We are largely a clinical institution where we spend hours—sometimes 80 hours a week—treating people. But we actually have begun to do research regarding the use of cocaine. I think a lot of the information that I present now is important even though it is not yet in print.

During the past 5 years, we have actually seen approximately 1,900 youngsters exposed to cocaine during pregnancy. These are youngsters who presented with positive toxicologies. Ten percent of that number were referred to me because of known problems. Of course, we don't know what the other 90 percent of the children look like.

I can say right now that by age 5 many of them are beginning to present to the pediatric department for the first time; that is, many of the youngsters exposed to drugs do not present with problems in the newborn period, giving a sense of false security both to parents and to physicians alike. Many of these youngsters are just now presenting with learning disabilities. And, unfortunately, they've been overlooked because they've not had any behavioral problems.

Unfortunately, I think what this says is that we are really facing the unknown with regard to hundreds of thousands of youngsters. Right now the estimate of the number of youngsters exposed to cocaine in utero per year is about 750,000 children. That's probably an under estimate of the number.

Briefly, if I can just tell you a little bit of what our research has shown—I'm going to take just about 3 minutes to do this. It's not to alarm you but it is to talk about some of the things that perhaps you have not read in print.

About 15 percent of the youngsters who have presented to me during the past 5 years will have lifetime handicapping conditions; that is, they will not be able to take care of themselves. They have either been retarded, autistic—which is something I will talk about in a moment—or have cerebral palsy. These are youngsters who will depend on the Government to take care of them for life.

On the positive side, however, I'd say the overwhelming majority of youngsters, if dealt with early on, will probably do fine and will probably go on to have a normal life span, will be able to contribute to society. But that's with a big "if," that's if they are dealt with very early in life and if their families are involved in some kind of a program that intends to reach every aspect of society.

In other words, many of these youngsters really are not coming out looking normal until they are about 5 years of age and after they've been worked with in some kind of a preschool program.

What we've seen thus far are the following:

Language abnormalities, communicative abnormalities, are the most common of all the abnormalities seen in children exposed to cocaine. I can say language is the basis of learning; it's the basis of understanding—and it is not something that is minor.

About 90 percent of all youngsters exposed to cocaine in utero presenting to us have language problems. They may speak well but in many cases they don't understand what you're saying. They're presenting with real problems in school if they're not worked with early on.

Hyperactivity—the typical kind of thing you see on TV is common in about a third of our youngsters. These are children who appear to be wound up with a motor. They jump up on my desk. They are up on my file cabinet. It's an incredible thing to see.

I can tell you right now, we don't treat them with Ritalin in most cases. We put them in very small classrooms. We get the families to understand how to under stimulate them, and we have found ways of working with them that can make them much less physically active.

Cerebral palsy, a finding that initially we did not want to relate to cocaine, is certainly on the increase. Much of this is due to the incredible rates of prematurity and low birth weight that we're seeing.

I would say that for the first 5 years of looking at the drug problem, almost 40 percent of our youngsters were premature. As we go out to approximately 7 years of doing our research, I would say well over one-third of our youngsters are born prematurely and small.

A startling fact is that one-third of our youngsters have small head sizes. Now a small head size or a small cranium means a small brain, and a significantly small brain is a brain that cannot think well.

I mentioned autism before. Let me say this; autism is a neural developmental abnormality. It probably has some genetic basis to it, and it is a physical and mental abnormality that probably has some relationship to 30-odd medical conditions. We know that mothers who are exposed to German measles are much more apt to give birth to a child with autistic disorder.

We at Harlem Hospital don't know why, but we are seeing more autistic kids who have been exposed to cocaine than we've ever seen before in a lifetime. It is my feeling that cocaine and crack are triggering mechanisms to creating this disorder. And I certainly think the area of research has not even begun to tackle this problem.

Some of the other things we need to pay attention to are what the drugs have done to the fabric of society. Almost 40 percent of the caretakers of children today are grandparents—they are not the biological parent. In fact, at Harlem Hospital, only 25 percent of our children are taken care of by mothers.

Congressman Rangel hit it just right when he said that the family life is so different. It really is the kind of life we never thought about before—children being cared for by grandparents who are 70; in one case, 80 years of age; taking care of children 2, 3, and 4 years old. In one instance, we have a grandmother taking care of eight children, all because of the drug use by her daughters.

So we have youngsters who are in family situations that we don't consider normal. We have stressed out parents and grandparents, and we have children who will perhaps never live a normal lifestyle. This sounds terrible but this is the reality of what we're dealing with.

We have found, however, that there are programs that work. There are approaches that work. But none of them are simple and none of them are cheap. We cannot deal with the drug problem if we don't deal with the problems of society as a whole.

If I talk to mothers who are using drugs, they will talk about a lifetime of hopelessness, of abuse, of not having jobs; of really playing Russian roulette with their lives.

We have families that are tripled up, quadrupled up, 20 people to 2-room houses. We cannot expect families like this to go on and not play Russian roulette with their lives.

Preschool programs—I'm sure Dr. Powell will talk about this—absolutely work. Programs where we're working with mothers before delivery; and going out into the homes work. Programs where we try to reunite the mother with the grandmother work. In fact, the only way we're going to stop some of our mothers from having five, six, seven children is by actually trying to reunite the mother with the grandparent.

I don't want to paint a bleak picture but I think it's important for us to all sit back and say, yes, cocaine does do something to the brain, it does something to the body. It is truly a neurotoxin—we cannot escape that fact.

But I think, on the other hand, we know that things that can intervene in the life of the child and the family early on do work, but it is going to require an absolute massive assault by the Government, largely the Federal Government, on this war if we're going to make some of these programs work.

I think the leadership has got to come from the Federal Government. People have been so blasé about drugs. You see little kids shaking and trembling in their bassinettes. This is not the issue. The issue is that the majority of babies who are born look normal. It's what we have to face. What we have to face may take years and years of undoing and we've got to be committed as a nation to actually do that.

Thank you very much.

[The statement of Dr. Davis follows:]

TESTIMONY ON

DRUG EXPOSED CHILDREN-SPECTRUM OF ABNORMALITIES AND EFFECTIVE INTERVENTIONS

SEPTEMBER 13, 1991

CONGRESSIONAL BLACK CAUCUS

In large minority communities like Harlem, where poverty, inadequate education, lack of employment opportunities, histories of abuse and neglect, disenfranchisement and a sense of hopelessness are the norm, cocaine and CRACK have taken their toll and in many instances destroyed the fabric of family life as we know it. Cocaine use, however, is widespread throughout our land ... affecting all races and classes ... thereby raising serious questions about long term effects, not only on the individual exposed to the drug but on our nation as a whole.

As an Afro-American pediatrician both living and working in Harlem and servicing children in the Departments of Child-Adolescent Psychiatry, Pediatrics and Rehabilitation Medicine, I am in a position to describe the wide range of abnormalities seen in connection with intra-uterine cocaine exposure and to provide a unique perspective on the kinds of intervention strategies that work.

Cocaine is the number one illicit drug of choice among pregnant women in the United States with New York City registering a staggering 20 -fold increase in maternal cocaine use during the past decade. Between January 1986 and December 1990 approximately 1,900 children were born at Harlem Hospital Center with urines positive for cocaine. This represents 13% of all birth at the hospital during that time. Informal surveys of our mothers attending the general prenatal clinic reveal a rate closer to 25%. Some large inner city hospitals have reported rates of over 50%. Approximately one-tenth of the children born with positive toxicologies for cocaine at Harlem Hospital have been sent to me for evaluations because of developmental and/or behavioral problems. The spectrum of abnormalities seen have tremendous implications for school systems throughout

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the country and the society as a whole. The findings were as follows:

1. The majority of the mothers were poly-substance users with alcohol being used by over 50%. Alcohol can significantly interfere with growth and development.

2. Mean age of the mothers was 27 years.

3. The biological mother was the caretaker in only 25% of the cases.

4. The majority of the caretakers were grandmothers and foster mothers.

5. Prematurity occurred in over one-third of the cases.

6. Head circumferences were below the fifth percentile in one-third of the cases.

7. Interference with growth continued well beyond infancy.

8. Delays in language skills were noted in 90% of the children. Delays were seen in all age groups.

9. Most children presented with abnormalities by 18 months.

10. Delays in fine motor, gross motor and play skills were noted to a lesser but significant extent.

11. Hyperactivity and short attention spans were noted in over 30%.

12. Hypertonicity was noted in 30% with some of the children showing signs of cerebral palsy.

13. Autistic disorder, a rare disorder said to occur with a frequency of 3 - 10 children per ten thousand live births was present in 8% of the children .. an alarming rate.

Explosive behavior, difficulty interacting with peers, difficulty with transitions, indiscriminate attachments, feeding disorders and intrauterine strokes were all noted to a greater degree in this population than in other groups presenting to the clinic who were not drug-exposed.

Cocaine is a vasoconstrictor and thereby impedes the free passage of food and oxygen to the fetus. There is very little controversy about this effect. There is considerable controversy, however, about other reported effects. Results of our Harlem Hospital study, which have been accepted for publication by the Journal of the National Medical Association, reveal adverse effects not only on the vasculature but on the central nervous system as well. While some of the adverse effects were noted at birth, others were not noted until years later.

Effective early intervention programs work. There simply are too few of them. The Harlem Hospital Center program for drug-exposed infants and their mothers is sponsored by the Visiting Nurse Service. It is family focussed and involves home visits and assessments and interventions for the mother and child. The program begins at the birth of the child. Unfortunately we can service only 20 families. A psychiatrist, play therapist, social worker and a developmental pediatrician make up the staff. Children are referred to other specialists as needed. The program helps in myriad of ways to bring about a healthy caretaker - infant bond.

Pre-school programs are essential for all high risk children. There are numerous pre-school and daycare programs; however, only a few of them can effectively treat the drug-exposed child and his family. In February 1991 the New York City Board of Education collaborated with Harlem Hospital Center setting up a pre-school therapeutic nursery for 2 - 4 year old children exposed to drugs in utero.

There are seven children in each class plus two special educator teachers, a speech therapist and a play therapist. Psychiatrists from Harlem Hospital provide treatment for those children requiring in-depth therapy. A major component of the program involves outreach to School District 5, our neighborhood district. Teachers from the district have already begun to rotate

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on an 8 week basis through the school in order to become familiar with the spectrum of disabilities and intervention strategies that work.

Parent/caretaker involvement is essential. The typical caretaker of a drug-exposed child is a grandparent or foster parent. They are at times overwhelmed by the problems of the child.

Effective programs for drug-exposed children are insufficient for the number of children needing services. "Zero to Three" Legislation has been passed. It is a reality in only a limited number of communities. Monies have to be allocated to educational departments for the specific purpose of re-training teachers. They are so eager to learn how to deal with this population; however, this does not appear to be anyone's priority at the moment.

The Federal Government must expand its research in the field. We must develop effective drug reeatment protocols that work. Medical experts must be given opportunities to perform long term research studies to document what drugs do to the developing fetus. Research must be done to determine the degree to which the environment exacerbates the problems faced by these children. Harlem Hospital is a part of the New York State Consortium on Drug Effects on the Fetus. We will be submitting a grant in the Autumn to study the effects of cocaine and other drugs on the developing fetus. We will also investigate the role played by the environment. Research projects such as these should be funded.

As an Afro-American physician who has worked at Harlem Hospital for seven years and lived in Central Harlem for an entire lifetime, it is clear that cocaine is creating problems with children not previously seen. Many in the field have said that we are actually looking at problems of poverty. Harlem has always been poor! We are seeing something far beyond poverty.

Cocaine and alcohol are neurotoxins and the effects seen in our children were, to a large extent neurological in nature. Roughly 15% of the drug-exposed children I see at the hospital have handicapping conditions that will require a lifetime of care. The majority of drug-exposed children however, will do well if their needs are recognized early and intervention provided. With early intervention many of these children will not require special education after age 5 years. The Federal Government must take the lead. The monies are not available at the City and State levels. The very well being of our nation is at stake.

Respectfully submitted,

Evelyn Davis, M.D.

ED/hma

Evelyn Davis, M.D., Assistant Clinical
Professor of Pediatrics
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Mr. **Rangel**. Thank you, Doctor.

I do hope that, before this discussion is over, even though you've touched on the health and moral issue, we can also talk about what this is costing in dollars and cents. And since we guess so much in Washington, I have just said that each child, ultimately before they expire, would cost $1 million, and no one can challenge that. If we're talking about health care at $600 a day or $1500 a day in intensive care; if we're talking about continuous health support; if we're talking about the statistical data that indicates that these kids drop out of school, get into trouble, are incarcerated, go in and out of the criminal justice system—besides the pain and suffering, if you just looked at it in dollars and cents, it's a tremendous burden to just ignore this problem and not to prevent it from occurring.

Dr. **Davis**. Absolutely.

Mr. **Rangel**. You should know at our previous hearing we had the pleasure of listening to Dr. Davis and invited her back along with her colleague, Dr. Charlie Knight, from East Palo Alto, CA. Dr. Knight has crossed the country once again to share her expertise in this area with us on this Congressional Black Caucus weekend, and with the Congress on her last visit and assured us that she will continue to work with us and other parts of the Federal Government to indicate what we have to do to get a handle on this serious problem that faces us.

So personally and politically, I thank you for rejoining us, Dr. Knight.

STATEMENT OF CHARLIE M. KNIGHT

Dr. **Knight**. Thank you, Congressman Rangel.

My testimony is included in the packet so I think that what I will do is to tell the story of the little city of East Palo Alto, located in the second richest county in California—San Mateo; but we happen to be the poorest city in the State of California.

Along with having to cope with other problems, the city's infrastructure is being destroyed by drugs. The big question my board had to address was, what does a school district do when the infrastructure of the city is deteriorating? What kind of impact will that have on the quality of education?

The president of our board, Myrtle Walker, instructed me to begin to focus on the impact of deterioration of that city on the quality of education. This led us, of course, to address the problem of drugs in our school.

We found that our youngsters were being heavily influenced by the men who were selling drugs out of the park. The first thing we found is that third graders were entering schools with beepers. These beepers were used to communicate with the drug lords.

Our teachers were not prepared to deal with the child wearing a beeper to school. Now we're not talking about a beeper that I could afford. We're talking about the most advanced technology in beepers.

The teacher would see a youngster whose body looked as though it was vibrating, but would not hear a beeping sound. Well, they had moved from the beeper beeper to a vibrating beeper. So when the child began to tremble, naturally the teacher would say, Johnny, would you like to go see the nurse? And often the nurse would come in and remove the child.

Well, that beeper was notifying him that someone had called him to go make a drug run. Often our teachers said, I'm here to teach, how would I know that this kind of thing would happen in a third grade class?

So we began providing services for our teachers so that they would understand that there would be several different kinds of interruptions during the school day. Then their job, of course, was not to fall for that, but to immediately communicate with the office to be sure that somehow child protective services was notified and the probation department. And that's when East Palo Alto decided that this problem was so large that one entity could not address it.

So we went toward the development of a collaboration. We found out that child protective services had set aside some money to work with these youngsters. We found out that the health department also had funds to work with these youngsters. So between the health department and the school district, a collaboration was formed and we pooled our resources.

The top people—the director of child protective services, the superintendent, and the director of health services—came together and decided that we will focus on drugs for some continuity of effort and unity of focus to see to it that something did happen.

What happened there was the development of a parent/child intervention center that focused on not only the child but also on the child's parent.

We've been in this business now for 2 years. Let me just share with you some of the problems that we are encountering. First of all, we still have a problem funding the program. I could fund that program easily for $6,000 per student. That's very small compared to California's spending of $28,000 per child to incarcerate a child in the California correction facilities.

We are simply saying, just give us 6,000 of those dollars because we know the career path of these youngsters if we fail to intervene.

The other problem that we found is that we emphasize the care of the infant. We took that infant from birth. The beauty about this is, we are surrounded by great institutions—Stanford University and Stanford Hospital. So when a child is born at Stanford Hospital we are immediately contacted and are allowed to get that child from birth.

But once we received that child and began to provide day care while the mother participated in either treatment or some form of education, we found the greatest need was to work with the parent. We did not include funds in our budget to provide comprehensive services to the parent, so we had to go out to foundations and get money to do just that; and we did that.

The other problem that we found, though, is that after we worked with the parent and the child and they had adjusted to the program, was that there needed to be a transition period. Once we were able to get the parent, through child protective services and welfare, receiving checks, we found that the money that was received was often not used appropriately. They may pay their rent or they may not pay their rent. So we had to deal with eviction services and things of that sort.

So we came up with a new proposal to several foundations, which have not been funded, for a transition house for these parents. The children and the parent would live in this house for at least 6 months. And during that period of time, we would have an opportunity to assist that parent in the acquisition of parenting skills, in addition to helping her handle a budget and to work with the parent in dealing with the problems of babies who were prenatally exposed to drugs.

At the same time, allow the parent an opportunity with about five other parents, and there are about six, in our State, that we're allowed to work with in one house.

That program is currently being proposed to several foundations. If it is funded we will have some data to provide to other school districts and to other people who are interested in this area.

We also found, that as we began to determine the extent of the delays that were mentioned just recently, the assessment tools are inadequate. Unfortunately, those persons who are in the business of designing tools to measure either the performance of youngsters or their inability to perform were somehow outdated and inadequate.

So what we're doing now is working with a firm in an attempt to design some instruments that will adequately determine the extent of the language delays, the extent of that youngster's developmental delays, and other developmental delays. That will take some time but at least when we finish we will have some information. Right now we don't.

I would like to plead to OSAP, who has been just excellent in helping us pioneer this thing, as well as Congress, to take a close look at the money that is being given to researchers, to be sure that the research is something that is going to be helpful to those of us who will be providing services to these youngsters.

Some of the research I'm finding is recycled; it is nothing new. There is one particular case where the original research was done 10 years ago and what they have done is dust it off and give it back to us in a different form.

I would like to see some careful attention given to what these people are doing and the persons that they are supposed to be studying to be sure that these are real people. I'm finding a great deal of difficulty trying to follow the description of children that they say I am teaching or working with, with the ones that I'm actually working with.

So one of the things we will be doing with Harold Dent and Bill Pierce, two psychologists out of San Francisco, would be to try to put together some assessment tools that would be very helpful to school districts as they attempt to deal with this.

The other problem that we are having, of course, is that 50 percent of these youngsters were not with their biological mothers. They are often either with grandmothers or some other extended family member. No place in child protective services or any of the other social services in California address the problem of grandparents. Often grandparents do not even receive the same services.

So we're trying to work with these organizations to modify their program so that they will benefit the needs of these youngsters.

In addition to dealing with the grandparents, we also need to deal with the community at large; how these children are somehow nurtured by the community rather than having that community wind up being the violent place.

So one of the things that we are doing is to be sure that our schools are effective schools and, at the same time, they are schools where the community is rallying around them. In other words, we are establishing block clubs so that if there is a child leaving school who is accosted by a drug dealer, that child knows that there is a friendly house someplace, and that the house is designated by a certain symbol. That way, if a child is being pressured by drug lords to sell their drugs, they have a safe place close by to go. I can understand the problem here.

In California, if a minor is caught with drugs, the worst that can happen is an overnight stay in juvenile hall and that youngster is out. The youngsters know exactly the number of hours that they have to stay; it's about 14 hours in our State. So it is much easier, then, for a 14-year-old or for a 5-year-old to be caught selling drugs because there are very few consequences.

I would like to also make another plea, and that is, as programs are funded to focus on drug problems, that they provide direct services. Many of the programs provide some services that these people already have. We have several for their case studies or case management and things of that sort. But these ladies and gentlemen need direct services that will assist them in acquiring the skill they need in order to function out there in the real world.

Finally, for the school district in terms of achievement, we know that these youngsters come to school troubled. We know that they are hyperactive. We know that we will tend to use the same methods to cope with their discipline problem as other types of discipline problems.

What we would like to do would be to extend some of these funds into a school-age program. Now we've just received a small grant to do that for one class. One of the things we'll be doing is to bring in youngsters that we know were exposed to drugs and that are currently living in that kind of environment.

We would like to not label them and say this is the program for the drug children; but somehow provide the kind of instruction that will meet their problem of hyperactivity—their problem of tending to be violent at times when there is not that kind of provocation.

So we will then have to provide funds for in-service training of the teachers who will do that and for the parents of the children through a parent education center that our board has established for all parents, so that they will, at least, acquire those skills to deal with this new problem that we are having to face without the money coming from our State.

Our State superintendent just acknowledged our program so we are on an all-time high. The first thing that we tend to do as superintendents is to deny that there is a problem, particularly if there is no money to address that problem. Well, our State superintendent finally accepted the fact that we do have a problem of dealing with drugs in our schools.

We will continue to fight a good fight, but we really do need assistance and, hopefully, some monitoring of the kinds of projects that are coming out of programs that are being funded, particularly in those areas where they are designed to assess youngsters or provide direct services to the clients.

Thank you.

Mr. **Rangel**. Thank you, Dr. Knight.

[The statement of Dr. Knight follows:]

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Prepared Statement of Dr. Charlie M. Knight
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HEARING
before the
U.S. HOUSE OF REPRESENTATIVES
SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

1CONGRESSIONAL BLACK CAUCUS LEGISLATIVE WEEKEND

SEPTEMBER 13, 1991

"Educational Policy Implications for Serving Drug-Exposed Children"

Statement Prepared by:

Dr. Charlie M. Knight, Superintendent
Stephen J. Waterman, Assistant Superintendent
Magdalena R. Fittoria, Assistant to the Superintendent

Introduction

From your letter of invitation it is clear that this committee is painfully aware of the dangerous tidal wave of drug injured children approaching urban schools and threatening to drown the already struggling teachers and systems. (On March 8, 1990, the House Subcommittee on Children, Family, Drugs and Alcohol held a hearing titled, "Falling through the Crack: The impact of Drug-exposed children of the child welfare system.") The very name of this committee indicates that the House appreciates the difficulty of **eliminating** drugs and speaks instead of **controlling** them.

My small school district is already reeling from the first crest of the wave of children who enter with more than the usual disabilities resulting from growing up in poverty. At the same time we see funding eroding for even current programs. I cannot help but notice that our state legislature seems increasingly less willing to invest in public education now that the majority of students in California are not Caucasian.

Last fall, when the House of Representatives passed H.R. 1013 (Special Education re-authorization), it recognized the disproportionate numbers of black children, especially black male children who were being placed into Special Education Programs, and recommended research to find more effective ways to serve this group of traditionally underestimated young people. It also recognized that in utero drug exposure could result in increasing numbers of children in need of special services. The House bill contained a section calling for demonstration grants to schools districts for intervention programs targeted to these children. The House bill contained no categorical funding for these programs. By the time the bill became P.L. 101-476 that language was gone and the only special funding was for coordinating existing services as part of the program evaluation.

The Throw-Away Children

On Friday, November 2, 1990, the Oakland Tribune reported on a study which found that "One in three young black men in California is either in jail, on probation or on parole." Today's eighteen-year-old black man was in second or third grade in 1980. He was more likely to have been identified as "Educationally Handicapped" than his Anglo or Hispanic peers. He was more likely to have been retained in a grade than other students. He was more likely to have been suspended. He was, in fact more likely to have found his public school days to be an experience which alienated and disenfranchised him from the mainstream culture.

It should not have been surprising that in the mid-1980's, when crack cocaine became easily available, it would have met with a large group of thirteen-year-old black boys whose teenage rebellion was intensified by the low self image they had gained from being told they were failures by their teachers and who had quite reasonably given up on the system for more immediate and tangible rewards. Enter the teenage black girls whose rebellion is made more isolating because their dysfunctional families cannot provide adequate support. As teenagers, these girls face the same pressures toward sex and drugs and away from school which are faced by all girls. However, the boys they date are those who have found education to be futile; and the goals of steady job and small house seem vaporous at best when compared to the instant pleasures of sex and drugs.

The mixture has created a new generation of tragedy. The difference is that these least prepared mothers have infants who are extremely frustrating to raise.

If we as a country should have learned anything from the Japanese success, it would have been that our short-sighted view of reality and failure to invest in long-range goals, is crippling us today and threatens to destroy us in the future. California's spending on incarceration has increased by more than 500% in stable dollars over the past ten years, while its investment in avoiding incarceration has so eroded that spending in our students places us forty-eighth out of fifty states, and far behind other states with comparable costs of living.

Success Is Possible

I have not presented these facts out of bitterness, but out of concern for our future as a nation. We have enough research to be certain that children who are successful in school are unlikely to turn to drugs later, and that the most effective way to control drugs is to eliminate the market for them. It is a "Looking Glass" logic which places enforcement before prevention.

For the past 18 months, the Ravenswood City School District has been running a program for infants and young children born toxic positive, and their mothers. The program centers around therapeutic day care. Mothers are required to come to the center several times each week for drug and family counseling, parent training, preventive health care, and continuing education. The County's Child Protective Services and Health Departments provide a part-time nurse, a counselor and case management services. Our center serves 44 infants and children and their parents.

From our own early intervention program, funded in part by the Office for Substance Abuse Prevention (OSAP), we have learned that most children who come into this world affected by crack cocaine, can, after even as short a time as 24 months, behave so similarly to non-exposed children as to be indistinguishable. To achieve this level of progress, they need what all children need, a safe, stable, nurturing environment. Their problem is that they enter the world to the most unnurturing environment imaginable, and they would present a challenge to the most experienced and mature of parents. They are agitated and colicky, so they cry often and often fail to provide parents with hugs and smiles, cues which help parents bond with their children. And the parents...

The mothers of these difficult children are children themselves, undereducated, immature, without money, and usually without an available supportive family. The fathers are too often the black males who were called "disadvantaged," or "at risk," or "special ed" or any other names that made it acceptable for teachers to give up on them. The fathers are the boys whom we pushed out onto the street, whom we told in a thousand ways that they were too stupid to make it in school. They are the inmates of California's alternative-to-school, its burgeoning prisons. Thus these young girls are left to their own inadequate resources as they raise some of the most difficult children. They have no job skills and little education. It is little wonder that we have found them cutting the ends of the nipples from baby bottles so that they can put broken-up hamburger and lettuce into the bottles. It is little wonder that after being cooped up in a dank apartment with a screaming baby for days at a time, they escape into drugs and loud tv. The result, of course, is the birth and raising of a new generation of American children, malnourished, sickly, and unprepared for an education system which is unable to meet their needs. Instead of leading the United States with their energy and productivity, instead of providing the support our generation will need as we retire, this new generation will become a drain on the country's shrinking resources.

Crack Children Can Succeed

The good news is that it is not impossible for us to change this picture. It is not even prohibitively expensive to do so. We have found, and our findings are supported by other programs in the state and around the country, that programs can be developed which will minimize the damage these children suffer and even produce school age youngsters better prepared to succeed in school than many non-drug exposed children. The service needs the following elements:

1. **The program should start at or near birth.** Our best success has been with infants. The effects of good nutrition, routines, good hygiene and health care, and carefully designed activities have immediate payoff for the children and society. The children suffer fewer health problems, they are more often left with their natural mothers - both savings for society. Support during their early development means they are less likely to be late identified as needing special education in school, or welfare/prison as adults; this saves both society and the child.

2. **A program needs to be developed around the child and child care.** In spite of their inadequacy as parents, the mothers love their children and want to keep them. But the mothers need respite, support and training. A program centered around long term day care provides the respite, and allows the mothers to keep their children, thus giving them the motivation to come for support and training.

3. **The program needs to be in the community and run by a credible, community-based organization, such as a public school district.** The public schools in a poor community are the last credible governmental institutions. In contrast to may other community based organizations, the school district can work easily in partnership with county departments of social services, public health departments, and child protective services departments. Centralizing service in the community takes away the problems the young mothers invariably face such as getting transportation, and gives them a local, peer support network.

4. **The program needs to be long term.** Many programs for postpartum infants and their mothers end within six months. Mothers who were unable to stop themselves from taking drugs while pregnant will be unable to turn their lives around within six months. They need support as they move from drugs, complete their education and get settled into work. Concurrently, the children need the stability that can be provided by a nurturing day care/education center.

5. **The program needs to require mothers to attend parenting counseling at least several times a week.** The goal of the intervention must be two-fold -- benefit to both mothers and children. The few reliable predictive scales for children's later success in school indicate that the mother's relationship of the child is critical. In cost-benefit terms, it is cheaper for society to have children stay with their parents than to pay for foster care when the children are young, and prison when they get older. If the mother can be helped to change along with the child not only will this child benefit, but also later children will be healthy; she will be a contributing member of society, and her children will be a benefit instead of a burden.

6. **The program needs the assistance and cooperation of county agencies.** We have seen that without the tremendous support we have received from Child Protective Services (CPS), our program could not survive. By working together, our program goes well beyond what CPS could do on its own, and provides a community center for CPS to effectively work with several clients.

7. **The staff needs thorough and on-going training.** While teachers in general can benefit from more training in cultural sensitivity, and the special needs of their students, it is clear that any program which directly aims at serving this special population needs more intense and practical training in the cultural strengths and differences of their clients.

8. **The program needs sufficient, long-term funding through direct grants.** Funding must include both basic child care costs of the special services the children need, and the costs of coordinating with a myriad of organizations and agencies. In our case, our OSAP grant provides the costs of some of the special services and some of the extended child care; the county's Public Health Department provides health screening and drug counseling; CPS provides basic child care for the first six months and some counseling. We still ran a deficit of over $100,000 this year, caused by providing basic child care and facilities costs.

Based on our experiences, I recommend that funds be set aside for grants to school districts from the federal government, perhaps through OSAP. We have found this young agency to be most cooperative and supportive. If funding is routed through the states, a portion must be set aside for programs such as ours, run by local educational agencies.

The total cost of such a program is approximately $12,000 per child per year. By using existing county agency resources, the total cost would be approximately $8,000 per child per year -- of which basic child care is about $5,000. At this time, I know of only one other program like ours in California, and as of June it had not begun to enroll children. According to our information, no other school district in the United States has received an OSAP grant - probably because the funding guidelines do not provide for grants which are large enough for the school district to run the program without using its own general funds.

Public School Instructional Programs Lack Essential Elements

The greatest weakness of school age programs is that clients have already fallen behind. They have been in an average of three foster care placements; have rotated between mothers and foster care; or have elderly grandparents who have been trying to cope with them. Children's routines have been disrupted, they haven't been able to bond with an adult. They have often suffered from poor nutrition and lack of medical care and have had few pre-education experiences. Identification of children is more difficult. The drug symptoms are now so mixed with the problems of lack of nurturing that the developmental problems require greater skill. This weakness is followed by the lack of a focused family service program which includes health services, counseling, job training and parenting along with the educational interventions for children.

When these vulnerable students arrive in school, they are greeted by teachers who have many children to serve and who often lack both the belief that these children can learn and the skills to effectively instruct them. Further, federal programs for public school children only look at the visible needs of the children. The Special Education Legislation referred to above is an example of this fragmented approach to the problems of drug-exposed children. Likewise, ECIA, Chapter I and Title VII, bilingual programs focus on the children in isolation from their family and health needs. Schools lack the local resources to provide for the children in the context of their families - an essential component to successful intervention. Funding for school-age children must be broad enough to encompass staff development as well as the parenting, counseling and other services we have found to be successful in our Parent-Child Intervention Program (PCIP).

The federal government needs to lead the way in providing holistic programs for school age children, while concurrently supporting additional research.

Teacher Education Programs Ignore the Problem's Existence

There is little doubt that new teachers in our state are entering their profession unequipped to teach minority students, let alone drug affected students. Funding for teacher education programs must require direct experience in urban schools, and must require teacher candidates to participate in both cultural orientations and classwork in dealing with disabilities. These classes in turn must be taught by practitioners who are familiar with the manifestations of drugs and the dysfunctional environments of children.

[redacted]

The task we face is formidable. However, it is neither so expensive nor so difficult that we should abandon our efforts. Your leadership in assuring research and demonstration and training programs is critical. I appreciate what the House has done, and urge you to continue your efforts.

July 23, 1991

Mr. **Rangel**. Also testifying not too long ago before the Select Narcotics Committee was Dr. Diane Powell, who runs an exciting program based right here in Washington, DC, one of the very few programs of its kind in the Nation that deals with the problems that these children have. And she, too, has been kind enough to come back to share her ideas and her project with us on this weekend.

I should let the panelists and the audience know that most all of the panelists have agreed to get together after this forum is over to see what we can do to educate others and to help ourselves with the programs that we're involved in, because, unfortunately, there are not that many people in the Nation who are doing what this panel is doing. And we have to get local, State, and especially the Federal Government, to be more supportive.

So thank you again, Dr. Powell, for being with us, and we are anxiously awaiting your testimony.

STATEMENT OF DIANE E. POWELL

Dr. **Powell**. Good morning, Mr. Chairman, and members of the committee and caucus.

I'm delighted that during this 21st session of the Black Caucus that this is an issue that is being addressed. I know that all of you have watched the media as it has shown us pictures of young children who are lying tremulously in their bassinettes in the hospital wards.

I know that you have seen pictures of babies that are being maintained in houses for children who do not have families. We call them boarder babies. And I think that the media has certainly done a job of allowing us to open our eyes and to see that problems exist.

But I think that one of the things we want to keep focused on is that when the cameras stop rolling and the publicity is not being printed, that we still have children who are entering into our schools.

I'd like to stress to you that when we look at children who have been prenatally exposed to drugs, one of the things that we want to keep in mind is that they are children first. They are certainly at risk, but they're children first.

I'd like to walk with you into a classroom on the first day of school and invite you to understand that when these children walk into the classroom doors, they do not present that significantly different from their nonexposed peers. They also are excited about being in school. They look attractive. They have bright eyes, shining faces. They want to be hugged and kissed by the teachers. They want to explore the environment. And they're dressed like any other child that you see.

There are certainly some differences in terms of the degree, the intensity and the frequency of behaviors that we might see. But they're children; they're not a biogenic underclass. They're not shadow children. They're not crack babies. They're not those children. They're children. They have names. They have parents. They have grandparents. They have a father. They came from somewhere, and there's a place for them to go.

I think that as we begin to talk about early intervention and programming, we can paint a picture for these children that is somewhat more optimistic than sometimes the press would have us believe.

Let me talk to you a little bit about project DAISY, its inception, and its importance in terms of its mission here in the District, and perhaps some national implications.

In 1989, our previous superintendent sat down with a collaboration of representatives of several agencies here in the District to ask and to try to begin to formulate answers to the questions:

What will we do when these children enter our schoolhouse doors?

Are we really prepared to respond to all the needs of the children?

And what do those needs look like?

We're all afraid.

I think that once people have voiced the position that we are afraid, we're anxious, we're not sure, we don't know, we don't have the answers, I think the real work begins.

By bringing together a collaboration across agencies we were able to look at the fact that all of these children will be impacted upon by agencies across the District of Columbia, but one of the agencies that all of them must matriculate through, is the school system.

Certainly we found that a lot of our children who were 3, 4, and 5 years old coming in to the classrooms have never had a physical examination. They may or may not be living with a biological parent. And as my colleagues expressed, the majority of our parents are grandparents and in some instances, great-grandparents.

We have some who are as old as 85 who are raising children who were left with them as babies. Some of these receive these children when they turn 3 and 4.

One of the things that they say to us is that, we love them but we're tired. And that's something that I think that we have to be cognizant of. These people are tired.

Sometimes they don't live with a grandmother—they're not that fortunate—so they live in places like Grandma's House, or they go into other social service agencies where boarder babies are kept and reared and they go to school from there, but they're still children when they come to us.

Project DAISY is a special initiative. It's a project that was designed to provide developmentally appropriate settings for young children between the ages of 3 to 5, in regular classroom settings that are integrated with nonexposed peers.

One of the things that we want to keep in mind is that we do not know that these children need special education yet. And we do not want to assign a life-long sentence of being handicapped to children who may not present that way.

As you listened to Dr. Davis, she said to you, 15 percent of the children may have special needs. And we recognize that there are those children who will need to be placed in special education, but 85 percent of those children will enter into the regular classroom. And our children, we feel, are being served appropriately in an integrated setting that offers full inclusion with particular supports to respond to the behavioral concerns and the cognitive concerns that these children may present.

Project DAISY is currently located in four schools in the District of Columbia. Each of those schools is in different quadrants of the city, in neighborhoods where children are "at risk". We have, in each of our classrooms, two adults—a teacher and an educational aide—and we serve 15 children. Ten of those children in each of the classes are not exposed to drugs, five of them are. The five children who are exposed are coming to us because of our relationship with the birth to 3 tracking system that operates out of D.C. General which gathers aggregate information on children across the District who have been prenatally exposed to risk factors. Therefore, we can go out and interview those mothers and offer to them the types of support that our project offers.

What does our project offer?

We can offer reduced class sizes. We offer the supports of an interdisciplinary team, a clinical psychologist, a clinical social worker, a speech language pathologist, and supports from the medical community.

We can offer developmentally appropriate environments that have been restructured to look at the developmental needs of children.

We can offer multiage classrooms where being a little delayed doesn't really make a difference because your peers are of different ages.

We can offer classrooms that have materials that allow children to participate in hands-on learning experiences—hands-on science, hands-on math.

We can look at curriculum intervention such as high scope or the Errin curriculum which was developed in California. We can look at strategies that we are using to respond to the behaviors that we have observed in the environment.

We've noted, to date, approximately 53 behavioral characteristics that these children exhibit. And we can say for sure that no two children present exactly the same. Some of these children have one of these characteristic behaviors, some of them have 35. We know that they are all different.

But we do know that when we look at these children in relationship to their nonexposed peers, that some of those same characteristics which many of them have, are exhibited by their nonexposed counterparts. We know that children who are young do have a lot of motoric activity. We know that children who are young do not always stay in their seats. We know that children fidget and squirm. We know that children cry and have problems in separating from their mother.

We also know that features such as maturation over time and the opportunity to look at models of peers that are exhibiting the behaviors that we desire make a difference in terms of what children look like when they enter in September and when they exit in June.

We are now moving into the second year of our project. And as we looked at our project and we looked at the needs of the clients we were serving, and certainly being in the District of Columbia—which is a predominantly black school system—we had to look at how we could offer support and be culturally sensitive to the African-American community here in the District of Columbia.

One of the things that we began to look at was how do you deliver services in a cultural context to reach out to families when you know that the primary caregiver is a female and generally a senior citizen?

One of the things that we have introduced into our project is called Home-Based Intervention. What that means is that we take the supports directly from the classroom into the home. We can share with grandmothers in the homes strategies that work in the classroom. And we can share those strategies to support the needs that we're seeing that these children are exhibiting.

One of the things that my colleagues have indicated that they noticed in these children, which is generalizable, are deficits in language. Oftentimes we find that children have problems in expressing themselves as well as understanding what is being said and making sense of that in the environment.

We found that a lot of this has to do with the fact that when these children were young they didn't have that initial bonding experience with a significant other, so they didn't have a lot of exposure to language models. So we're working a lot on language modeling.

We're also looking at things like how do children play and interact with their environment and we recognize that some of our children do have extremely aggressive thematic play. But modeling makes a difference, and certainly early intervention makes a difference in these children.

Some of our children came into class and they were unable to sit or attend for periods of even 30 to 45 seconds. We found that that has certainly been different in terms of the models that we have seen over time in our program.

So I'd like to say in closing, that we want to look at strategies. We want to look at training preservice, in-service. And we want to look at recognizing that these are children first. But the picture that we paint for them is not bleak; it can be extremely optimistic if we pool our resources and talents in responding to the needs of these young children.

[The statement of Dr. Powell follows:]

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CHAIRMAN RANGEL, MEMBERS OF THE HOUSE COMMITTEE AND BLACK CAUCUS... I AM HONORED TO COME BEFORE YOU TO PARTICIPATE IN YOUR COMMITTEE HEARING AS YOU ADDRESS THE ISSUE OF THE EDUCATION OF CHILDREN WHO HAVE BEEN SUBSTANCE EXPOSED. THIS PROBLEM HAS BEEN DOCUMENTED TO HAVE ADVERSELY AFFECTED HUNDREDS OF THOUSANDS OF CHILDREN. WHILE MOST DOCUMENTATION REFLECTS THE HIGH INCIDENCE OF THIS PROBLEM IN MINORITY COMMUNITIES I.E. (AFRICAN AMERICAN, HISPANIC) THERE IS NO GROUP RACIALY OR ECONOMICALLY THAT HAS GONE UNAFFECTED. THE PROBLEM IS PERVASIVE AND IT HAS HAD AND WILL CONTINUE TO HAVE A DEVASTATING IMPACT ON OUR CHILDREN UNTIL WE DEFVELOP STRATEGIES ACROSS MULTIPLE SYSTEMS TO RESPOND TO THIS CRISIS. DUE TO THE PREDOMINANCE OF LOW INCOME MINORITY WOMEN WHO CURRENTLY RECEIVE HEALTH CARE FROM PUBLIC HEALTH CARE FACILITIES, STUDIES SUCH AS THE NAPARE STUDY IN FLORIDA INDICATE THAT MINORITY WOMEN ARE 10 TIMES MORE LIKELY TO BE IDENTIFIED AS DRUG USERS. WHAT WE DO KNOW IS THAT WOMEN USE DRUGS ACROSS ETHNIC GROUPS AND THAT THEIR SUBSTANCE ABUSE IMPACTS ON THE CHILDREN.

THE NATIONAL ASSOCIATION FOR PERINATAL ADDICTION RESEARCH AND EDUCATION (NAPARE), HAS CITED FIGURES WHICH PROJECT THAT AS MANY AS 375,000 INFANTS ARE BORN ANNUALLY TO WOMEN WHO USED DRUGS DURING PREGNANCY. THIS FIGURE, APPROXIMATELY 11% OF ALL NEWBORNS ARE VIEWED BY SOME AS A CONSERVATIVE ESTIMATE. FURTHER , IT IS IMPORTANT TO NOTE THAT THERE ARE APPROXIMATELY 50 THOUSAND BABIES BORN IN THE UNITED STATES EACH YEAR WITH ALCOHOL RELATED DEFECTS SUCH AS FETAL ALCOHOL SYNDROME AND FETAL ALCOHOL EFFECT.

IN ORDER TO ACCOMMODATE AND EDUCATE THESE CHILDREN WE MUST PREPARE TEACHERS IN A MYRIAD OF WAYS. FIRST AND FOREMOST WE MUST STRESS THAT THESE " CHILDREN ARE CHILDREN FIRST". SECOND AS EDUCATORS WE MUST RETHINK THE WAY IN WHICH WE DELIVER EDUCATIONAL PROGRAMS. IN OUR URBAN COMMUNITIES WE MUST DEVELOP A CULTURAL CONSCIOUSNESS. THIS EFFORT MUST EXIST INTERNAL AND EXTERNAL TO THE AFRICAN AMERICAN COMMUNITY. WE MUST EDUCATE PROVIDERS RELATIVE TO THIS HISTORICAL CONTEXT OF THE FAMILY AND THE ROLE OF THE MATRIARCH WITHIN BLACK FAMILY SYSTEMS. THIS UNDERSTANDING IS CRITICAL AS WE NOTE THAT MANY OF OUR YOUNG CHILDREN ARE BEING RAISED BY GRANDMOTHERS AND IN SOME CASES GREAT GRANDMOTHERS. WE ALSO MUST CONSIDER THE ROLES THAT OTHER PEOIPLE SUCH AS CLOSE FRIENDS, "PLAY SISTERS, BROTHERS" BRING INTO THE LIVES OF THESE CHILDREN AND LOOK UPON THEM AS AN IMPORTANT FAMILY RESOURCE.

AS WE EXAMINE THE EDUCATIONAL IMPLICATIONS OF THE MOTHERS DRUG USE WE MUST KEEP IN MIND ONE VERY CRITICAL FACTOR.................

TO DATE THE JURY IS OUT AND THE VERDICT HAS NOT BEEN RENDERED RELATIVE TO THE NUMBERS OF THESE CHILDREN WHO WILL NEED SUPPORTS BEYOND THE REGULAR CLASSROOM. CONSEQUENTLY , WE NEED TO REFOCUS OUR THINKING ON THE CHILD'S STRENGTHS VERSUS Operating USING A PURE DEFICIT MODEL. **IT IS CRITICAL THAT WE ATTEMPT TO SUPPORT AND MAINTAIN THESE CHILDREN IN SETTINGS WITH THEIR NON EXPOSED PEERS TO THE DEGREE POSSIBLE. IT IS NOT APPROPRIATE.. NOR IS IT FINANCIALLY FEASIBLE TO SEGREGATE THESE CHILDREN FROM THEIR PEERS ...UNLESS THE DEGREE OF SEVERITY OF THEIR NEEDS WOULD MAKE ACCOMMODATIONS WITHIN THE REGULAR CLASSROOM SETTING UNREASONABLE.**

RECOMMENDATIONS FOR FULL INCLUSION ARE SUPPORTED BY FINDINGS FROM THE NAPARE DEVELOPMENTAL STUDY WHICH SUGGESTS THAT OF THE 300 CHILDREN THEY STUDIED ALMOST 100% TESTED WITHIN NORMAL LIMITS COGNITIVELY AND THAT THEY CAN BE TAUGHT AND CAN LEARN. THAT MANY OF THE NEUROBEHAVIORAL DIFFICULTIES SEEN AS INFANTS ARE NOT APPARENT AT AGE 3 AND 4. CONSEQUENTLY THESE CHILDREN EXHIBIT COMPETENCIES WITHIN THE SOCIA, EMOTIONAL, MOTOR AND INTELLECTUAL DOMAIN WHICH PLACE THEM WELL WITHIN NORMAL LIMITS.

INSTEAD OF EXCLUDING THESE CHILDREN FROM OUR CLASSROOMS .... WE NEED TO TRAIN TEACHERS TO WORK WITH THESE CHILDREN AS THEY WOULD ANY OTHER "AT RISK" CHILD IN THEIR CLASSROOM. **KEEPING IN MIND THAT THIS IS THE ERA OF FULL INCLUSION... ONLY IF THE NEEDS OF THESE CHILDREN ARE SO SEVERE THAT THEY NEED ALTERNATIVE SETTINGS SHOULD WE ENTERTAIN SPECIAL EDUCATION PROGRAMMING. OTHERWISE IT IS OUR PROFESSIONAL RESPONSIBILITY AS EDUCATORS TO BRING THE SUPPORTS DIRECTLY TO THE CHILD WITHIN THE CONFINES OF THE REGULAR CLASSROOM.** IT IS CRITICAL THAT WE LOOK BEYOND THE LABEL TO THE CHILD. THESE CHILDREN ARE EAGER TO LEARN AND EQUALLY AS EXCITED AS THEIR NON EXPOSED PEERS.

THE SUPPORTS NEEDED FOR THESE CHILDREN MUST BE MULTIFACETED AND SHOULD INCLUDE SPECIFIC STRATEGIES AND REASONABLE EDUCATIONAL ACCOMMODATIONS . THESE MODIFICATIONS WILL FALL IN THE AREAS OF:

.STRUCTURE OF THE ENVIRONMENT
.STRUCTURE OF THE LEARNING MATERIALS
.STRUCTURE OF RELATIONSHIPS..CHILD -TEACHER, CHILD-CHILD, CHILD TO GROUP, AND TEACHER TO CHILD
.STRUCTURE OF THE CONFIGURATION AND USE OF SPACE

E TO THE KNOWLEDGE BASE WHICH HAS BEEN ESTABLISHED IN EARLY
H EFFORTS IN PROGRAMS SUCH AS HEADSTART WE KNOW THAT EARLY
NTION AND SUPPORT IS ESSENTIAL AND THAT IT DOES MAKE A
NCE.

NSEQUENTLY, IN DESIGNING PROGRAMS TO RESPOND TO THE UNIQUE
F THESE YOUNG CHILDREN THERE ARE COMMON CHARACTERISTICS
HOULD BE FOUND IN EFFECTIVE EARLY INTERVENTION PROGRAMS.
THESE CHARACTERISTICS, ARE A PART OF PROJECT DAISY AND
:

LLABORATIVE CONSULTATION ACROSS AGENCIES
OME BASED INTERVENTION
ARENT TRAINING AND SUPPORT GROUPS FOR PRIMARY CARE GIVERS
EVELOPMENTALLY APPROPRIATE CLASSROOM PRACTICES
XPERIENTIAL LEARNING STRATEGIES
ULL INCLUSION OF CHILDREN IN INTEGRATED SETTINGS
ULTIDISCIPLINARY SUPPORTS INCLUDING:
    .EDUCATORS
    .SOCIAL WORKERS
    .CLINICAL PSYCHOLOGISTS
    .SPEECH PATHOLOGISTS
    .MEDICAL SUPPORTS /SCREENING
INTENANCE OF CHILDREN IN CLASSROOMS WHICH DO NOT EXCEED 15
ILDREN TO 2 ADULTS
LTI AGE LEVEL CLASSROOMS
SEARCH TO DOCUMENT EFFICACY
AINING TO GENERAL EDUCATORS

WE WILL NEED TO BOTH TRAIN PRE SERVICE EDUCATORS AND RETRAIN INSERVICE TEACHERS; ARMING THEM WITH A CADRE OF TECHNIQUES. IN SOME INSTANCES WE WILL NEED TO ASSIST TEACHERS IN REFORMULATING THEIR THINKING ABOUT WORKING WITH THESE YOUNG CHILDREN. IN ESSENCE THE ROLE OF THE REGULAR EDUCATION TEACHER WILL HAVE TO UNDERGO A DRAMATIC SHIFT.

AT THE PRE-SERVICE TEACHER TRAINING LEVEL UNIVERSITIES MUST EXPAND PERSONNEL PREPARATION PROGRAMS TO INCLUDE TRAINING OF TEACHERS TO:

.WORK COLLABORATIVELY ACROSS AGENCIES

.TO PARTICIPATE IN SHARED PROBLEM SOLVING AND DECISION MAKING

.EMPHASIZE COMMUNITY BASED PROGRAMMING TO INCLUDE WORKING CLOSELY WITH FAMILIES

.PROVIDE TEACHERS WITH ALTERNATIVE CURRICULAR APPROACHES (DEVELOPMENTALLY APPROPRIATE) AND STRATEGIES

.FOCUS ON DATA COLLECTION AND DOCUMENTATION

IN ADDITION TO THE EFFORT MADE LOCALLY BY SCHOOL SYSTEMS AND THOSE RECOMMENDED FOR CONSIDERATION BY UNIVERSITIES; THE FEDERAL GOVERNMENT CONTRIBUTION SHOULD BE EXPANDED TO INCLUDED:

1. RESEARCH IN REGULAR EDUCATION PROGRAMS TO SUPPORT THE MAINTAINACE OF THESE CHILDREN IN SETTINGS WITH THEIR NON EXPOSED PEERS

BEST COPY AVAILABLE

2. SUPPORT OF EFFORTS TO DEVELOP CURRICULA AND CURRICULUM ADAPTATIONS TO SUPPORT INNOVATIVE INSTRUCTIONAL PRACTICES

3. FUND INNOVATIVE PRESERVICE EDUCATOR PROGRAMS IN EARLY EDUCATIONAL INTERVENTION

4.BLOCK GRANTS TO SCHOOL SYSTEMS TO EXPAND , DEVELOP OR CONTINUE PROGRAMS DESIGNED TO ADDRESS THE EDUCATION OF THIS GROUP OF CHILDREN

MEMBERS OF THE COMMITTEE...

IN CLOSING, I URGE YOU TO APPROPRIATE FUNDS TO SUPPORT THESE CHILDREN NOW TO MAXIMIZE THE BENEFITS GAINED FROM EARLY INTERVENTION, VERSUS A DELAYED REMEDIAL OR CORRECTIVE APPROACH WHEN THESE CHILDREN REACH MIDDLE OR ADOLESCENT YEARS. LEAST WE WAIT THE COST.. WILL BE ASTRONOMICAL.. ONE THING THAT WE KNOW IS THAT EACH OF THESE CHILDREN IS UNIQUE. NO TWO CHILDREN PRESENT AT THE SAME TIME WITH ANY UNIFORM LEARNING OR BEHAVIORAL CHARACTERISTICS.

CONSEQUENTLY, WE MUST PROVIDE THESE CHILDREN WITH INTENSIVE INTERVENTION SUPPORTS IN ORDER TO WARD OFF A CRISIS IN THE FUTURE.

. FINALLY, WHAT WE CAN SAY IS THAT EARLY INTERVENTION DOES WORK AND FOR MANY, MANY OF THESE CHILDREN THE PROGNOSIS WITH EARLY INTERVENTION AND SUPPORT WILL BE OPTIMISTIC.

submitted by:
Dr. Diane E. Powell
Director,Project DAISY
District of Columbia Public Schools
September 13, 1991

Mr. **Rangel**. Thank you, Dr. Powell.

We've had some idea as to the medical impact on the child, the health situation in the hospital, and we'll talk more about that.

We are now seeing how people are wrestling with the problem in the school setting with special projects. Now we'll try to move and see what is really being done to better equip the teachers to know that this is with us and what we have to do in the future.

I'm glad that my friend, Mike Timpane, the president of the internationally known Teachers College of Columbia University, has agreed to share his ideas with us—with this panel. And also to get his commitment that in our community we're going to have to get some more panels about what should be included in the curriculum of our schools since there's some controversy as to whether or not African history has been properly portrayed as with the rest of history.

I am glad when Columbia says we can deliver that message in a less fiery way than has been suggested, but in an accurate way.

And at the same time, I've asked Dr. Powell whether or not we can get both of you to get Columbia to perhaps share the technical background in health and education with Dr. Primm and the Federal and local and State people to see whether we can really put a package together to deal with the problem that we all know is going to severely hit this Nation.

I remember when Beny Primm testified in front of this very committee—how many years ago, Beny—on AIDS?

Dr. **Primm**. Eight years ago.

Mr. **Rangel**. Eight years ago, Beny Primm testified about the AIDS epidemic that was going to sweep this Nation and the impact it was going to have on minority communities, and no one knew what he was talking about. Now, unfortunately, they do.

So, President Timpane, thank you, once again for always being available and we're anxious to hear what input you have on this serious subject.

STATEMENT OF P. MICHAEL TIMPANE

Mr. **Timpane**. Thank you, Congressman Rangel—my Congressman.

Just to respond to what you said at the very outset of your remarks, there should be no doubt that educators need help, and need help badly in this area. And not to be too confessional, but none more than myself, because your call to testify has caused me to try to put myself through a 2-week crash course to learn the things I should have known long ago; so I can give you some personal testimony that that is not the way to solve the problem. We need much more than 2-week crash courses to solve these desperate problems.

Let me briefly relate a vignette that I learned when I asked several of my colleagues at the college who are far more well informed than I.

Mr. **Rangel**. Would you share with the audience how many teachers you produce annually out of Columbia alone?

Mr. **Timpane**. Sure. Columbia Teachers College probably produces about 500 teachers a year. And, of course, the colleges of the

City University and of the other universities in the cities—several thousand more.

This is a true story about a young, gifted 5-year-old African-American girl from central Harlem. We have a federally funded program called Project Snyergy, which is supposed to identify gifted young children from that neighborhood for early education.

Jenny, which is the name we give her, is one of 11 children under the age of 13. Her mother is addicted to crack and her absentee father is an alcoholic; and she often comes to school disheveled, not in clean clothes. On several occasions when the community member, who is our parent liaison in this program, tried to visit the home, she was refused entry.

Jenny's neighborhood school ranks 617 out of the 619 in New York City. It's in a tough neighborhood. The kindergarten class that Jenny attends has 28 children, one teacher, and a paraprofessional. As you would expect from what we've heard this morning, out of the 28 children, several are impaired due to substance abuse of their mothers during pregnancy; several are on Ritalin, unfortunately; and several live in homeless shelters.

So you'd say that the daily challenges that face Jenny are insurmountable but that's by no means the case. Jenny is a great survivor. Let me read what our professor, who supervises this program, said about her:

> Her inquisitive nature, combined with her tenacious spirit, has enabled her to thrive in Project Synergy's summer program at Teachers College. Her academic profile is astonishing. She can intuitively carry out sophisticated math computations; is teaching herself how to read; can weave imaginative stories in the pretend area, and is passionate about playing card games with her teacher.
>
> A standardized math assessment places her at or above the 85th percentile, notwithstanding the very difficult home and school environment that she has encountered so far.

I tell the story because I think we need to understand that there are a full range of children's gifts among this community and we shouldn't downplay the high end; we should not misunderstand that there are remarkably gifted children who are in the kind of risk that we're talking about today and not just average kids.

But we have to wonder how many Jennys have already been abused and permanently harmed and didn't show up in our program. We have to worry a lot about will Jenny herself make it. The perils of her life are hardly over, at the age of 5.

There's one other thing that we should worry about: when will the Federal Government wake up to the possibilities here, because this is a federally funded program, and just an example of what the Federal Government can do if it wants to.

To characterize the state of awareness and preparation and training of educators—it's hard to generalize, I suppose, but the picture that I have gained is, indeed, of inspiring instances of dedication and of success—and we've heard about many of them here and in the very compelling testimony that you heard in July on this subject.

But it's the unfortunate case that they're isolated at best. Most schools and most educators are woefully unprepared to cope with the myriad complexity and consequences of children with drug-induced disorders and disabilities.

As I said, we need help, and we need help fast.

Let me just go quickly through five areas where I think program development could happen rather quickly and effectively if the will and the resources are there.

The first is what I'll call generally multidisciplinary school-based programs. What I'm saying here, while it applies particularly to these children, really applies to all children at risk and it probably applies to all children; and that is that the schools simply have to open up and become places where many agencies and many professionals can come together to deal with the myriad problems, as has been stressed earlier—the myriad problems that most such children face. It is rare and it probably never occurs that the children we're concerned about come to school with one problem and one problem only.

These are syndromes of problems that we are dealing with; and if we are not prepared in the schools to deal with the array of those problems that the young child presents, we are unlikely to succeed.

And yet, schools, as institutions, have typically not been open to that kind of breadth of services. It's better today than it has been, but it is not the tradition. The tradition of the schools has often been, when the problem gets serious, to refer the child to another agency. And all the blame is not on the school, by any means, because the other agencies are just as bureaucratic and turf-conscious as the schools and they're anxious to have that referral if that's the way that they garner their resources and make their track record.

So for schools and all agencies, we've simply got to lower the bureaucratic barriers and come together and provide comprehensive services for these children, for all children at risk. And as has been said this morning, the earlier, the better.

Second, we do need to strengthen and enhance special education programs in the schools, which are that part of the school curriculum that has had the responsibility of addressing the needs of children with emotional and social handicaps and learning disabilities.

As I've said, the schools can't do it all; but the schools have a role, and certainly to reconceptualize and reorganize special education programs in ways that deal effectively with the unique needs of children with drug-induced disabilities is one such role.

The symptoms described this morning and in previous testimony and in the literature are very confusing, and it is easy for the unprepared teacher or rehabilitation worker to confuse the symptoms of drug exposure with other kinds of learning disabilities, other kinds of physical symptoms.

The report that I have is that this often results in inaccurate diagnosis and inappropriate treatment even within special education, which is trying earnestly and wholeheartedly to deal with these children.

Such training is simply rarely available and there are very few materials for special educators to use either.

The third intervention I would urge is one that again you referred to in your remarks and that have been referred to by previous speakers, that in addition to paying attention to the current generation of children who are entering our schools, we really must bear down and commit and expand our efforts in educational programs that are specifically designed to prevent a second generation of this problem.

Substance abuse and drug abuse education, properly designed, works, and the evidence is growing that it works.

A couple of specifications I would make are that these programs should certainly initially be targeted toward high-risk children, and they should be looking at these children's psychological and social development as well as their educational achievement in trying to educate them about substance and drug abuse.

It should begin early and it must focus on the progressive development of knowledge and attitudes and decisionmaking skills. If there's one thing that's clear, it's that children need good information and the tools to make good decisions. And another thing that's also clear is that simple admonitions or scare tactics will not work. Children need in this, as in so many areas of their life, good, solid information and skills with which to cope with an issue that is going to come back at them and come back at them and come back at them throughout their educational careers; and they have the strength and the knowledge and the skills to deal with it again and again and again.

I think to a significant extent these drug abuse and substance abuse education programs must be readily integrated as learning modules into the curriculum. If it's taught off to the side; if it's obviously an add-on or a tack-on to the school program, it will go the way of so many other add-ons and tack-ons. So whether it's in health education, whether it's in the social studies, whether it's in the multicultural curriculum that we must develop, the issue must be, obviously, a central and integral part of what goes on in the schools.

The program has to tap into and take advantage of the communication channels and the community settings that these kids are plugged into, because most of their time will not be spent in school, but will be spent elsewhere. So it needs to have that kind of breadth.

In sum, it's really programs that emphasize helping young people to resist peer pressure, build self-confidence and self-esteem; and to do that in the school setting and out, those will be the effective programs.

Fourth, we must talk about teacher preparation and teacher preparation institutions. We are just at the beginning of the road in training teachers, new teachers, and teachers in the classroom not only how to cope, but also how to succeed with these children.

At Teachers College, we've instituted a number of special courses and workshops that all of our preservice teachers now need to take, as well as in-service programs for teachers in the schools, and we have developed some program training materials for educators. But we, and I suspect other schools of education, have just started on the massive job of training and retraining America's teachers to deal effectively with drug-exposed children.

Now what should the Federal Government do about this? Let me just talk about a couple of things.

I have a simple suggestion to start with—that we discover and then rejuvenate an Office of Comprehensive School Health—that at least used to exist in the Department of Education, and we think it still does—as a way to begin to have some policy authority and administrative oversight to coordinate in a systematic way all of the Federal programs that could have aspects that bear on this issue, and that could also help with a systematic effort such as the National Diffusion Network in the Department of Education—to develop successful prevention and intervention education efforts in this area.

I think an even more important issue is whether and how we should develop a categorical program containing moneys that have been earmarked and set aside for the kinds of things we've talked about here today.

I think that my answer to "whether" is "yes," but it's a qualified "yes." Because my answer is—in the short run, yes; in the long run, I think we might want to think more carefully about it. Let me tell you what I mean by that.

In the short run we have a desperate need to build a knowledge and information base through added research. We have a desperate need to train and retrain the leaders in education and in other professions in how to deal with this issue.

We must have those moneys and have them targeted in the short run, if in the long run these young people are going to have access to the variety of services and resources that knowledgeable people in schools and communities will have to have to address their problems.

But I want to put in a word of caution about imagining a permanent operating program, lest it become another pigeon hole into which we will drop these young people.

The range of services and professionals must all be involved in the long run. So at least as a way to start the conversation, I wonder if we shouldn't think about highly targeted necessary developmental activities in the short run, but have in mind that in the long run what we really need to do is infuse the entire education program with the kinds of knowledge and skills that we've talked about here today .

I haven't had time to develop a dollar estimate on such a program, Mr. Chairman, but, needless to say, I'd be pleased to provide it if you are interested.

Let me conclude with one other encouragement for you. The Gallup poll on American education just came out a week or so ago about the public's attitudes toward schools.

And of all of the administration's proposed national goals, rendering America's schools free of drugs and violence commands the highest degree of support among the American people, point one. But yet, point two, it is the goal that they believe will be the most difficult to accomplish.

So I believe we are moving in the right direction. I believe we have strong evidence that not just the people in the communities most hard hit, but the people of this Nation in general, are ready to support some vigorous national leadership in this area, and I know you will provide it.

Thank you.

[The statement of Mr. Timpane follows:]

STATEMENT OF

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Testimony presented before the House Select Committee on Narcotics Abuse and Control of the U.S. Congress
The Hon. Charles B. Rangel, Chairman

September 13, 1991

Mr. Chairman, members of the Committee, thank you for your invitation to appear before you today. I am honored and grateful for this opportunity to represent American educators, this time on a matter of critical importance to both Congressional policymakers and the education profession--the problem of prenatally drug-exposed children, its impact on America's youth and our communities, and the challenge that this problem presents to American schools and teachers.

Having read the testimony given before this Committee in July, I shall not revisit what has already been covered; numerous witnesses have described in considerable detail for the Committee the scope of the problem we face, the impact of prenatal alcohol, crack-cocaine, and other drug abuse on developing fetuses, the resulting developmental delays and other anomalies observed in preschool and school-aged children, and the crisis in education that is being created for what are already overburdened and underfunded schools that are now being asked to respond by educating these children. While there are inspiring instances of courage and even successful efforts being assiduously pursued by dedicated groups of educators and others, unfortunately these are isolated.

Most schools and most educators are woefully unprepared to cope with the myriad complexities and consequences of children with drug-induced disorders and disabilities. The response to date has been well-intentioned but ill-conceived, too often characterized by denial, panic, inappropriate diagnosis and referrals, and confusion. In short, schools and educators need help, and we need it fast.

What, then, do schools and educators need to meet the challenge of educating drug-exposed children as they come through our schools? Let me focus on several major areas: the need for multidisciplinary school-based service-delivery programs, the need for enhanced special education programs, the need for a renewed commitment to and emphasis on primary prevention through school- and community-based health and drug education programs, the need for teacher preparation and specialized training, and the need for a limited federal initiative to seed and support efforts in such areas.

The Need for Multidisciplinary School-Based Programs

First, the unique and challenging needs of this population of children require a multidisciplinary approach to service delivery and educational intervention which recognizes the extraordinary complexity and numerous dimensions of the problem. We need to encourage and support schools in developing multidisciplinary school-based teams to deal with the existing crisis and current treatment needs of children who have been exposed to drug abuse prenatally.

The existing service delivery model that has evolved which is perhaps best suited to addressing the problem is one that encompasses the range of

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diagnostic, treatment and referral services that can be made available to children and their parents. School-based clinics, with which the nation's urban schools have had the most experience and much success during the last decade (especially in the areas of adolescent pregnancy prevention), can be a starting point for delivering a comprehensive range of counseling, educational and medical services that will be required by this population of school children. In addition to the normal range of educational and other services required by the average healthy school-age child, drug-exposed children will require a variety of specialized diagnostic services. These will include sophisticated neuropsychoeducational evaluation, speech and physical therapy, educational remediation, vocational guidance, and even psychotherapy. Too many schools in America today are ill-prepared to deliver such services.

The school-based clinics, where they exist, can be a focal point within the school system to conduct early identification and evaluation, intervention, and treatment programs. The multidisciplinary teams working with the clinics need to have individuals with the training and program materials to address a multitude of issues, including learning disabilities, emotional problems, and a host of behavioral and medical problems, all of which bear on the educational and achievement potential of the child. Most schools and their teachers, however, are not prepared to deal with such children by integrating them into the regular classroom (mainstreaming, as we like to call it), do not have sufficiently skilled teams of teachers and other professionals with the specialized training to cope with the demands such children make on their existing special services, and do not have the population-specific educational and training materials to facilitate development of their learning and coping skills.

Enhanced Special Education

Second, special education programs--that corner of the school curriculum that historically has had the responsibility for addressing the needs of children with emotional and social handicaps and learning disabilities--need to be enhanced if such programs are to cope with the unique needs of children with drug-induced disabilities. Special education teachers need to receive specialized training that will enable them to meet the special needs of students with acquired disabilities related to alcohol and drug abuse. It is critical that a working relationship between rehabilitation professionals and special education teachers be established for each disabled student as early in the schooling process as possible. Moreover, the susceptibility of special students to influences that foster misuse of drugs points to the need to develop new programs which focus on the prevention of drug abuse within the context of special education. Finally, with the influx of drug exposed students into schools, special educators will need to differentiate students whose difficulties stem from substance abuse and those whose difficulties arise because of learning handicaps unrelated to alcohol and drugs. The attention deficits, poor psychomotor skills, memory deficits, and developmental delays that characterize both groups will make this difficult. To appropriately serve these distinct groups of students, school professionals must differentiate between the two and design intervention strategies that are appropriate to their respective needs. Thus, research and program development to do this are needed.

Early Intervention and Prevention Education

Third, apart from addressing the current generation of children who will come to school with impairments due to prenatal drug exposure, the federal government must renew its commitment to and expand its efforts to educational programs specifically designed to prevent a second generation of such children from coming through America's schools. Over two decades of research and program evaluation studies in alcohol, drug, and health education has shown that when such programs have measurable goals and objectives, are grounded in an appropriate theoretical framework, and are taught by professionally prepared interventionists, with the support of the school to successfully implement a program, such programs do, indeed, achieve their goals. What specifically should such programs do?

1. Such programs should be targeted toward identifiably high-risk children and their families, and be appropriate to both the level of psychosocial development and academic achievement (in terms of reading level and comprehension) of at-risk children. Such programs should begin early in school and focus on the progressive development of knowledge, attitudes, and decision-making skills that facilitate adolescents and young adults to behave responsibly in the face of pressures from media advertising, the entertainment industry, peer groups, and adults that place children at risk for drug abuse. This is especially important for adolescent females living in urban areas for whom the risk of pregnancy is great. Programs designed to help adolescent females resist engaging in the use of drugs and unprotected sexual activity should be a high priority, as should be treatment programs for pregnant women who are already addicted

to drugs. Additionally, good prenatal care and early intervention programs which apply techniques designed to help infants negotiate their environment and which facilitate the process of infant and mother bonding should be expanded. Schools can play an important educational role in cooperating with other health and social services agencies at the local level to work with young pregnant women through such program, by providing specialized educational programming and counseling.

2. Such programs should have the potential to be readily integrated as learning modules within the context of existing educational programs. In most schools, programs that are readily integrated into the overall school curriculum have been shown to have a greater chance of being successfully implemented than those that are not.

3. Such programs should be designed to take advantage of the salient interest of at-risk children and the communication channels and community settings through which they are most likely to receive information, as identified through systematic needs assessment. New program development efforts should take the views and perceived needs of at-risk children into consideration when identifying strategies and educational activities designed to reach such children.

4. Such programs should possess the essential elements of successful school-based health education programs, i.e., be theory-based, specify measurable goals and objectives, utilize trained educational professionals, and include an evaluation component. Programs that emphasize helping young people to resist peer pressure, build self-confidence and self-esteem have been shown to be especially effective in many areas of drug-use prevention, and could be adapted to address the

needs of young women who are at risk for drug abuse and pregnancy. The National Diffusion Network has identified a number of national health and drug education programs that possess these essential elements; however, more federal effort is needed to assist school districts and their communities to obtain the necessary technical assistance and resources to adapt and implement these programs.

Such programs should extend beyond the classroom into the workplace and other community settings where at-risk children, pregnant adolescents, and their parents can be reached with educational programs that parallel and reinforce school-based programming. Programs that reach children and adults through special community groups, such as churches, youth organizations, and voluntary organizations, and that utilize peers and involve parents who can help present information, should also be developed and encouraged.

Specialized Teacher Preparation and Training

Fourth, teacher preparation institutions need to be supported to develop and implement specialized teacher preparation and training designed to familiarize teachers with the special educational needs and appropriate educational techniques and strategies to address the needs of such children. At Teachers College, for example, we have instituted a number of special courses and workshops designed to equip pre-service as well as in-service teachers with alcohol and drug and health education strategies that can be used in the classroom. In addition, program training materials for educators working in schools and other community settings are desperately needed. Thus, teacher preparation needs to provide educators with the requisite understanding, motivation, and skills to implement programs with fidelity and effectiveness.

Federal Initiative to Support of Such Efforts

Finally, let me say a few words about what it will require to operationalize what we already know can work in schools and the other community settings. As the Committee is well aware, numerous policy options are available, but at varying costs, political feasibility, and level of social benefit. As I see it, the policy issue before the Committee is how best to engage and support schools and teachers to employ strategies to intervene in the cycle of poverty, pregnancy, and drug abuse, while at the same time ensuring that policy alternatives from which we choose are fiscally responsible, practical, and have a chance to work in the context of the economic and political realities facing America's schools, whether they be urban where the need is perhaps greatest, or in the suburban and rural communities of this country. In addition, any prescription for educational intervention must be grounded in a political consensus about what it is we are attempting to achieve and how much we are willing to pay. Thus, designing and delivering the range of educational and social services for drug-exposed youth and their families I have described presents some formidable challenges as well as opportunities for schools and for federal and state government.

As an initial step, I strongly encourage the Committee to consider rejuvenating and empowering anew what used to be called the Office of Comprehensive School Health in the Department of Education to serve as the body with policy authority and administrative oversight for coordinating a systematic effort to identify through the National Diffusion Network existing prevention education programs that have demonstrated success. This office could play an important clearinghouse role in providing technical assistance and limited grant support to communities where the need is greatest, and have the responsibility for encouraging the dissemination and monitoring of program implementation with state offices of education.

In addition, should a categorical program, containing monies that have been earmarked and set aside for such students, be set up to support these efforts on the behalf of such students? In the short run, yes; in the long run, no. We need an infusion of monies in the short run to build the knowledge and information base through additional research, to build or enhance effective models of intervention, and to train and retrain leaders in education and other professionals to address the problem. We need the infusion of monies in the short run if we are to provide in the long run the access to the variety of services and resources that knowledgeable people in schools and communities will require to address this problem on a continuing basis. The aim of our short-run categorical effort should therefore be to remake the total environment of the drug-exposed child, rather than to establish a permanent narrow cateogry of financial aid for operating programs

This federal involvement should provide for incentives and support to communities and school systems, including initial funds to establish school-community coalitions and private sector initiatives to establish the necessary school-based programs designed to meet the need. This funding, designed to seed program efforts in schools, might be authorized for between three and five years. A condition of the awards would require that communities devise a plan by which they would undertake ownership of the funding of such activities by the end of a five-year sunset period. This approach has been successfully demonstrated in an increasing number of federal efforts designed to encourage communities in community risk reduction and other educational efforts, and could be a good alternative to establishing new and costly categorical programs.

Conclusion

Let me conclude by saying that, happily, I think the public is eager to support efforts to address this problem, and, if you look at the results of the recent Gallup Poll of the public's attitudes toward schools, it is clear that of all the Administration's national goals for education, rendering America's schools free of drugs and violence receives the greatest support by citizens across the nation, and yet it is the goal they believe will be most difficult to accomplish. We are moving in the right direction. Those of us in schools and in the education profession stand ready to be partners with federal and state government in working to help drug-exposed children to achieve their educational potential. Much work needs to be done. I and my colleagues at Teachers College eagerly look forward to working with you in the months ahead.

Thank you, ladies and gentlemen, for your consideration.

Acknowledgements

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Mr. **Rangel**. Mike, on that closing note, I was going to really try to wait until we all finish before I started raising questions, so maybe I would raise the question and ask you to think about it and then give the answer during the discussion.

I went to a so-called national law school, and what does that mean? It meant that it attracted students from all over the country and prepared them to go back to their States and then find out about the law in their States.

It meant I had to prepare for the bar the same way you just described; take a crash course in order to pass it.

Now we're dealing with a problem that, even though it's national in nature, you don't really have to be an expert to identify the communities which have more than their share of this particular problem.

So the question has to be, how do you prepare teachers to be national teachers when they need a special type of training?

Now, there's a lot of discussion about African-American schools and Afro-centrics and a variety of other things. But I think basically what people are screaming out for are additional resources to better prepare the teacher to educate that child. And you can call it what you want in the city—black, Hispanic.

But they're saying that we cannot take the mold of colleges that train teachers and just pump them out and then have this teacher from Anywhere, USA, come to Harlem and say, good morning, students. You know, she may get cursed out and that may be their way of saying, good morning—you know, depending on how they were greeted when they got home from school.

My question is, if you're looking for national leadership, where would I go to find out where are the national leaders in education?

In other words, we will pass out a bill that the committee put together—none of us are experts; it's an outline of a bill.

But the truth of the matter is, it would just seem to me that if I were a doctor and saw people dying and nobody seemed to be responding to the epidemic, that I'd go to a conference of doctors and scream out and say, we've got to alert our nation as to what's going on—as Beny Primm tried to do and no one listened.

So billions of dollars are now being poured into research but we cannot catch up with the problem as much as we would want.

Now we have educators seeing what is happening with the students getting burnt out. They are seeing the dropout rate, seeing what happens to the kids that drop out, and saying that the Federal Government should do something.

I wish desperately that we had a Democratic President so that when I knocked him or her, people would know it's not a partisan effort.

But we are motivated in this Congress and guided simply by budget restraint—nothing more or less. Even the authorizing committees that have the hearings and specialize in subject matters are directed by the appropriations committee and budget restrictions.

So when the President of the United States says that he wants to be the education President, I just have to go to sleep believing that presidents of colleges that produce teachers agree that he's going to be the education President; or that the National Education Association people would say, wow, isn't this great, we've finally got an education President. And that teachers all over the country would say, it's our time in the Sun, things will never be this good again because we've got an education President. And Members of Congress would say, support the President because this is really what we've needed for so long and we're finally getting it.

Instead, I got a red pamphlet from the President telling me that they're trying to decide what we're going to need in the year 2000 in terms of education.

Mike, this isn't a question of black schools or schools for addicts or schools for poor kids. It's a question of survival of black folks in this country. It's a question of whether our kids are going to end up dead, shot, addicted, in jail, or cut off completely from the American dream. Even if they don't fall in the above category, the kids hear optimistic speeches and say to themselves, they're not talking about me.

So, therefore, when we do get together we can't talk about any national programs because the whole Nation isn't being hit with the same severity as a certain segment of the population. We're going to need you and also Bob Chase and Al Shanker and back home, Sandy Feldman, to mobilize those people. They have the same professional standards to say, this is what's hit my profession, this has happened on my watch. And whether you're a mayor, or a Governor, or a President, we don't care what happens, but don't tell us about a budget when, indeed, this is an emergency.

You should know that the President has declared, and the Congress has concurred, that the Persian Gulf was an "emergency"—budget restrictions don't apply.

The savings and loans crisis is an "emergency." The budget doesn't apply.

Now I challenge anyone to tell me what is more of an emergency than this. The same way when Beny Primm was talking about the AIDS epidemic, if we had moved then, would we not have been saving money? Would we not have protected the national security and the budget?

So whether we do it after this panel or whether you can scratch out some notes as to where we go, I want you to know that preparing legislative outlines might be good for our press releases but until we can get that head of steam, where someone can say that this has to be treated differently because it is a national emergency, nothing is going to happen.

This educational plan is what the President is so proud of, written by an outstanding Secretary of Education. So what do you have? You have an outstanding Secretary of Education and a man who wants to be remembered as the education President. And we've got a booklet here, "America 2000: An Education Strategy," which is supposed to outline the direction and the goals which every community in America should be trying to achieve.

The reason why this language is used is because it is an accepted fact—and Bill Paxon here is a personal friend of the President so feel free to challenge anything—it's an accepted fact that the Federal Government's role is not to get involved in these types of problems.

So that's one thing we're going to have to overcome, that the President and the Secretary truly believe that this is the extent of the national mandate. And what we do will be in the areas of higher education. But don't talk to us about lower education because that's local school board responsibility.

I think we have to shadow that to say that, as Beny's department has moved forward now, what's the budget for drug addict treatment? Eleven billion?

Dr. **Primm**. Approximately $11 billion.

Mr. **Rangel**. Eleven billion bucks. And still they would say it's a local responsibility, where the funds go now to the States, because we don't have the national treatment programs. He's here to try to perfect that, to have accountability.

So I'm saying that if the panelists truly believe that this is not just a local problem but that a national response is necessary, we're going to have to fashion how that is going to be presented to the Federal Government, and it's not going to be presented by passing resolutions.

It's going to have to be done with political strength by experts so that every Member of Congress would know that in addition to tenure, pensions, and salaries, that the elected officials know that curriculum, resources, and the ability to produce kids that can learn and move forward, graduate, and make a contribution is so important that their ability to get reelected will be jeopardized if they don't respond.

Anything short of that will allow us to put out any release that we want without fear of being challenged. And we're in the process of getting our release out now. So we need help.

Adding to the dialog will be Bob Chase, who is the vice president of the National Education Association. He has personally been involved as a fighter in improving the quality of education himself and now has brought those talents to the national level. He serves on the advisory committee of Future Educators of America as well as the board of the National Council for Accreditation of Teacher Education.

So, Bob, it's not as though we expect answers from you to these issues but we do hope that we can expect your participation as we come back together to collectively develop a strategy to support the President's ambition to become the education President.

Robert Chase.

STATEMENT OF ROBERT CHASE

Mr. **Chase**. Thank you very much, Congressman.

Before I share some thoughts with you, let me react a little bit to your comments. If I overstep my bounds, it probably won't be the first time, as Mike knows.

Let me just indicate that since 1983, those of us in education have kind of thought that this was our time in the Sun. Unfortunately, the Sun has been shining for a long time now—8 years. And unlike what is usually the case, it has not assisted us as we would like to be assisted in making sure that educational opportunities for all of our kids grow as is oftentimes the case when things do get that kind of Sun.

We would be only too happy to be of any assistance that we could be in helping you achieve your goals because I think they are the same as ours.

Let me also just in somewhat of an oblique reference, perhaps, indicate that not only do we have folks who claim that they wish to be known as the education President, but we also have folks who claim that they wish to be known as education Governors, and dare I say, Congress people and Senators. And other than make those claims and make those wonderful speeches, there are too few—too few—who go beyond that and provide the necessary leadership and the necessary courage as you have done to assist in achieving that goal.

So, hopefully, all of us working together will be able to help those folks achieve the stated goal of being the education whatever that might be.

To get on to the subject at hand, I guess it's inconceivable that at one time—if we look back maybe 10 or 15 years ago—for us to be able to think that we'd be faced with a problem of the magnitude and dilemma that we're currently faced with, that we would see children who would be born of parents and women who were addicted to drugs, and that the physical problems, intellectual problems, emotional problems, social problems, that are in fact concomitant with that kind of a situation, would be anywhere near as great as they are today.

We've heard of the programs that exist from some of the previous speakers, obviously excellent programs that are doing an enormous amount of work. But as Mike Timpane said, unfortunately, these are isolated. And they don't reach anywhere near the number of kids that need to be reached. When young people arrive at our school doors with these kinds of problems, we cannot hope—even hope—that our schools can achieve what's necessary for all of these kids if they're going to be doing it alone. It's much, much broader than that.

This past July, at the NEA's Representative Assembly, our delegates adopted a number of principles to help guide Federal, State, and local agencies in developing policies and programs to meet the needs of alcohol- and drug-exposed children.

I have included those principles and additional comments in the prepared statements that we submitted to you.

But allow me to share with you some of what our schools need to assist these children. We must develop, and dare I say the "f" word—fund—appropriate educational programs for alcohol- and drug-exposed children.

Educating children is expensive. Children with disabilities represent 1 out of every 10 in our public schools. Our programs to serve them require $1 out of every $5 spent for public education. Federal assistance for such programs amounts to only 4 percent of the total cost.

The complex problems associated with drug- and alcohol-exposed children are in some instances unique, and as has been said by previous panelists, additional research in effective ways to overcome these disabilities is really essential; we believe this to be an appropriate role for the Federal Government.

Such research could become the bases for curriculum, methodology, guidance programs and other programs which could be disseminated through both printed material, in-service programs, preservice programs, community development programs, and the like.

Teachers and other school staff will need access to quality in-service programs—quality in-service programs related to these needs, and both children and school staffs will need access to counseling on an ongoing basis.

It is possible that some chapter 2 block grant funds could be made available for these purposes, just as block grant funds are presently used for other types of in-service education.

And yet, we hesitate to say that because the Department of Education and Congress itself continues to add their list of purposes for which chapter 2 funds can and should be used, while at the same time, appropriations for block grants decline.

Congress is considering new legislation to enhance teacher education, including the proposed teacher academies, and these could serve as the locus for continuing education and program development to meet these important training needs.

Additional State and Federal resources should be provided to establish programs for early identification and appropriate intervention. Courts, hospitals, community service agencies, and schools must work together to address the complex physical, developmental, economic and social conditions that affect these children.

We urge Congress to consider legislation that would provide resources and technical assistance to communities in order to enhance coordination by improving communication.

Low adult/student ratios should be supported in all classroom settings with an enrollment of alcohol- and/or drug-exposed youth.

Ironically, schools and communities that are most likely to enroll drug-exposed students frequently have the highest class size. And with the economic situations that many school districts are facing today, these class sizes are becoming larger and larger and larger, so that the individual attention and needs of these students just physically cannot be met.

Drug-exposed children need 1-on-1 interaction to advance academic developmental and social skills goals. They also need to be exposed to caring adults as positive role models, especially since all too often they don't have these at home.

Finally, while NEA supports drug education and enforcement, our society has not paid sufficient attention to, or provided adequate resources to, drug treatment. For those already chemically dependent, education, in many respects, is too late, and enforcement without treatment is too little.

Congress must support programs to assist women who use alcohol and/or drugs during pregnancy, including treatment, job training, and education, when appropriate; and parental and family life education.

Such programs can be effective, only with the support of families and others at the local level. But the Federal Government can and should provide resources and technical assistance to assure access to appropriate services.

We appreciate this committee's leadership in identifying the needs and coming up with the solutions in this area. And as I indicated to you, we're not only willing, but anxious to be of assistance.

Let me digress for a second and just talk with you a bit from a teacher's point of view and also from the point of view of just being a person in this country.

We have long, long said that we are a Nation that loves and cares for its children. Congressman, I say to you, we've not done very much about that.

The statistics affecting our children in this country are in fact a national disgrace. I believe that it takes national leadership, not just from Congress, not just from the administration, but from all of us who are involved in any way, to turn this around and eradicate this scourge.

We in schools cannot do what is being asked of us to do by ourselves. We cannot do it when resources are constantly being cut back. We cannot do it and deal with the other problems that are being placed upon us daily. It must be a community effort; an effort put into place by all of the people in this room who in fact have a concern. Mr. Timpane is absolutely right.

The Federal Government needs to open up its programs. And State, and local governments need to do the same. And there needs to be a coordination of effort. There need to be systemic changes, not only in our schools, but in the way all agencies that relate to children work.

We can sit around and we can talk about it, but unless we're willing to do something about it, unless we're willing to do something about it in a way that's going to make a difference—then I'm not sure where our place in history will be, but I don't believe it will be very high.

I happen to believe that if the Federal Government wants to do something, that it can do it. I think you've given us some examples in your earlier comments. If Federal, State, and local governments want to take care of the needs of our children, together we can do it. But it's going to take some risks and it's going to take some political courage, and some courage on the part of us who are in the educational field and the health field, and all of the helping professions. And it's also going to take some courage on the part of the business community to step forward and do what's right.

Hopefully, with your leadership and the leadership of the folks on this dais, we will in fact be able to move forward and make those differences and make those changes for the sake of our kids.

Thank you.

[The statement of Robert Chase follows:]

LEGISLATIVE INFORMATION

STATEMENT
OF THE
NATIONAL EDUCATION ASSOCIATION

ON DRUG-EXPOSED CHILDREN
AND THE
EDUCATION SYSTEM

PRESENTED TO
THE SELECT COMMITTEE ON
NARCOTICS ABUSE AND CONTROL
U.S. HOUSE OF REPRESENTATIVES

BY
ROBERT CHASE
VICE PRESIDENT
NATIONAL EDUCATION ASSOCIATION

SEPTEMBER 13, 1991

Mr. Chairman and Members of the Committee:

I am Bob Chase, vice president of the National Education Association which represents more than 2 million professional and support education employees in the nation's elementary, secondary, vocational, and postsecondary schools. I appreciate this opportunity to speak to you about an acute problem facing our nation and our schools: the growing numbers of children entering school who were born exposed to drugs or alcohol before birth.

It has been common knowledge for many years that children who are exposed to alcohol, tobacco, and/or other legal or illicit drugs are at a developmental disadvantage. Infants who have been exposed to alcohol or tobacco in the womb are more likely to be premature or underweight at birth and to exhibit a variety of health effects related to insufficient oxygen.

Such affected children have presented a challenge to both health care providers and the schools for many years. Our society can hope to reduce behavior-based risks to infants and children with education, public awareness, and proper prenatal care and counseling programs. Education and counseling are designed to appeal to understanding and the innate concern a mother has for a child. Sadly, they are of limited effectiveness in addressing a pernicious and growing problem -- the victimization of infants and children whose parents are addicted to crack, cocaine, and other dangerous drugs.

For most of us, the idea that a woman would conceive and carry a child while addicted to drugs is almost incomprehensible. The emergence of crack cocaine on the streets of America in recent years has forced us as a society to rethink what is possible and what is not. The availability and highly addictive nature of crack dramatically alters nearly every aspect of the lives and communities it touches: their safety, economy, health, and mores. Teenage children become the de facto heads of households because they are the principle source of income for the family. Mothers sell their food stamps, literally taking food out of the mouths of their children, to pay for their drug habit. Families leave the door open to any one at any hour who has something to sell, to buy, or to smoke.

As one consequence, children who are affected by the drug addiction of their mother or father face more than physical problems. They are affected by a set of circumstances that hampers every aspect of their intellectual, emotional, and social development -- not only in the womb but, for many, every day of their lives.

Moreover, crack addiction is not simply a drug problem. Addiction contributes to the disintegration of families, neglect and abuse. Crack addiction is linked with promiscuity -- both as women trade sex for drugs and because crack is said to heighten sexual desire. Children born to crack-addicted mothers are frequently infected with syphilis, AIDS, hepatitis, or other diseases; they may have been exposed to a multitude of drugs in the womb; and they may have also suffered from malnutrition. Once born, they are likely to be victims of abuse and/or neglect. Even in the best of circumstances, their parents or other caregivers are likely to have a limited ability to deal with the intellectual challenges these children present because of their physical, emotional, and intellectual condition.

Children exposed to alcohol and/or drugs before birth have taxed the resources of the medical and social services communities for many years. Drug-exposed children are frequently born in a crisis, as a result of premature birth, hypertension of the mother, or distress of the infant. Once born, they require sustained and expensive treatment in an effort to overcome physical problems connected to poor prenatal care and even drug withdrawal.

Estimates of how many children are affected by this complex set of problems vary widely, from a low of 30,000 a year to as high as 375,000, the estimate projected by the National Association for Prenatal Addiction Research and Education. In either case, it is clear from both anecdotal and statistical evidence that they are entering our nation's schools in growing numbers.

America's public schools already face a set of daunting challenges resulting from social and economic conditions in our country. And while NEA has always supported access to public schools for all children, regardless of disability, it should go without saying that educating children with physical or learning disabilities is very expensive. Elementary and secondary students with disabilities represent approximately 11 percent of total enrollment, but programs to serve such students require about 18 percent of the total resources for public education. Drug-exposed babies who are coming of school age generally have multiple disabilities.

In recognition of the growing need for programs to assist such children, the NEA Representative Assembly this past July adopted a number of principles to help guide federal, state, and local agencies in developing policies and programs to meet the needs of alcohol and/or drug-exposed children.

- *State departments of education should be encouraged to identify, develop, and provide, with full funding, appropriate educational programs for alcohol- and/or drug-exposed youth.*

While many drug- and alcohol-exposed youth exhibit the same type of physical and behavioral problems as other children with disabilities, the complex of problems are in some instances unique. Additional research in effective ways to overcoming these disabilities is an essential and appropriate role for the federal government. Such research could then become the basis for curriculum, methodology, and guidance which could be disseminated through both printed materials and inservice education programs.

Clearly, as the problems associated with alcohol- and drug-exposed children worsen, as trends indicate they will, teachers and other school staff will need access to quality inservice education. Moreover, both the children and school staffs will need access to counseling on an ongoing basis.

It is possible that some Chapter 2 block grant funds could be made available for these purposes, just as block grant funds are presently used for other types of inservice education. And yet, the Department of Education and Congress itself continue to add to the list of purposes for which Chapter 2 funds can and should be used, even while appropriations for block grants decline.

Congress is considering new legislation to enhance teacher education, including the proposed teacher academies, and these could serve as the locus for continuing education and program development.

o *Each state should be encouraged to fund and make available in all school districts preschool programs that allow for early identification of alcohol- and/or drug-exposed youth and appropriate intervention strategies.*

As with any other disabling condition, alcohol- and drug-exposed youth benefit from early identification and intervention. Sadly, many of these affected children do not even have access to a basic, stable, nurturing home environment, much less the extraordinary remedial environment that would help compensate for the circumstances of their birth.

At present, federally funded community-based programs, such as Head Start, are designed to help identify the developmental needs of preschool children. But only about one of every five eligible children has access to Head Start because of limited resources devoted to the program. Moreover, many families do not take the initiative to enter their children into Head Start or other available programs that would help identify and assist such affected children.

Courts, hospitals, community service agencies, and schools must develop better strategies for working cooperatives to address the complex of physical, developmental, economic, and social conditions that affects these children. We urge Congress to consider legislation that would provide resources and technical assistance to communities to enhance coordination by improving communication.

Coordinated, community-based strategies for serving disabled children and students can help assure that children get the comprehensive and sustained assistance they need to be successful in school and in life. At the same time, coordination can lead to cost-savings by eliminating duplication.

- *Low adult/student ratios should be supported in all classroom settings with an enrollment of alcohol- and/or drug-exposed youth.*

One of the most essential ingredients in addressing children with serious obstacles to success in schools is the ability to provide substantial time and attention to the individual child's needs. Ironically, schools in communities that are most likely to enroll drug-exposed students frequently have the highest class size. In many school districts class size in the elementary grades is as high as 35 or 40 students per teacher.

Class size reduction is an essential element of any effective strategy to improve opportunities for drug-exposed children. Students with the kind of developmental deficiencies caused by exposure to drugs in utero will need significant, time-consuming assistance to keep pace with their peers. When behavioral problems exist, teachers must devote considerable amounts of time on social skills, including conduct and interaction. Moreover, since many of these children continue to live with parents who are chemically dependent, they need the support of caring adults, including the teacher and/or other school staff.

o *Alternative treatment programs for all chemically dependent pregnant women, with services provided on a graduated fee schedule, should be made available.*

Since 1985, the federal emphasis on the drug problem has been on education and interdiction. NEA believes these are two important elements in stemming the tide of drug abuse in this country. And yet, too little attention has been focused on the need for drug treatment programs. Moreover, treatment facilities for cocaine addiction and for pregnant women limits access even further.

A 1989 survey of selected hospitals, released by the House Select Committee on Children, Youth, and Families found that in Boston only 30 residential drug treatment slots were available in the entire city, while 300 mothers in a single hospital were cocaine users. The same study found that the waiting period for drug treatment in Los Angeles was reportedly 10 to 16 weeks.

While cocaine addiction generally has a higher recidivism rate than heroin or alcohol dependency, experiments with the use of antidepressant drugs are considered promising by researchers in the field.

Admittedly, drug treatment does not have the political appeal of drug education and enforcement. Nevertheless, it is essential. For those addicted or dependent on drugs, education is too late and enforcement -- without treatment -- is too little.

- *Punitive measures against women who use alcohol and/or drugs during pregnancy should be opposed, and counseling and parent education should be provided.*

To some extent, our society has turned morality on its head. Many of us were brought up to believe, "Hate the sin, but love the sinner." And yet, when it comes to drugs, our society seems to love the sin and hate the sinner. Television, movies, and other media glorify the fast life of drugs. Indeed, for young children able to make hundreds or thousands of dollars a night selling crack or other drugs, the drug culture does seem to be the path to economic success. And yet, when individuals fall victim to drugs or other chemicals, they are treated as criminals and pariahs.

Congress must support programs to assist women who use alcohol and/or drugs during pregnancy, including assuring access to treatment, helping with job training and education when appropriate, and providing parental and family life education to help them turn their lives around. Such programs can be effective only with the support of families or others in the community, but the federal government can provide resources and technical assistance to assure individuals have access to drug treatment, job training and education, child care, and other appropriate services.

- *State departments of education should develop a curriculum for students of child-bearing age that includes information on the high risk involved in using alcohol and/or drugs during pregnancy.*

NEA has long supported drug education programs as a cost-effective means of drug prevention. The Drug-Free Schools and Communities Act has provided considerable resources over the past five years to assist in developing materials, inservice education, public awareness, and other programs. And yet, drug education must be an ongoing effort, as all education programs are, as long as drugs are available. We support special efforts to deal with high-risk groups, including pre-teen and teenage youth, so they have a full awareness of the harmful affects of drug- and alcohol abuse on their children, as well as themselves.

We recognize that any drug program -- preventative or remedial -- is at heart an individual, a family, and a community program. Sadly, it is individuals, families, and communities who are most economically disadvantaged who are most at risk of the drug culture and its corollary problems.

We appreciate this committee's leadership in bringing attention to the needs and solutions in this area. And we pledge to work with you to gain -- not only attention -- but wide congressional and public support for effective drug prevention and treatment programs, and for education programs that meet the needs of these unwitting victims of the scourge of crack cocaine.

Thank you.

Mr. Rangel. Thank you, Bob, for that very moving testimony.

I hope that all of you on this panel would have some names of people that you would want to attend a closed door conference, perhaps in this room, with the Secretary of Education, and whoever else Dr. Primm might see fit.

We do have the economists and the educators before the Ways and Means Committee that have testified time and time again that we have to do more in education. And they're saying it from a self-serving position that they cannot be the producers and the exporters unless we do more in education.

So we will be able to provide a closed-door conference with national business leaders. We will be able to provide the national administration leaders.

But in your different disciplines, write down the names of the people that you would like to see invited to a no-press, no-press release, closed door type of roundtable discussion that would probably take place in this room. Because it could very well be that this crack baby epidemic might be what we truly need to capture the imagination of people.

And if Mike Timpane is right that the polls are indicating that America is aware of this crisis that we're having in our classroom, then perhaps this will shatter the political obstacles that many of us face. I know I can get more policemen than teachers. I can get more jails than schools. I can get more support for the death penalty than for life-saving equipment at Harlem Hospital.

So what we have to do is turn that around. And with business people who know that they need better than what we're producing, with educators who know that they need political clout to get what they need to work with—with our medical profession showing that it costs less to prevent illness than to cure it.

I'm convinced that the Administration is sincere in trying to obtain these goals. And once they admit the problems that we face as a nation, then the question about our partnership would have to be worked out.

But if Mike Timpane can come here with his candor, coming from the school that has gained an international reputation, and said that he had to bone up for the hearing, then clearly the national leaders in education that have problems going far beyond what he is talking about, need the type of expertise that these panelists have brought.

So whether we're talking about teachers, principals, school board leaders, associations, or whatever, write down who you think might make a contribution toward the discussion in assisting the Administration to move forward.

I agree with you, we will take on the National Governors' Conference. We will get in touch with Ray Flynn from the Conference of Mayors. We would ask them to send to us, not only the mayor that seems to be the best prepared to articulate the concern, but also the educator from the cities and States that can best articulate the need.

I can assure you that we will have someone from Darman's office to talk about cost as we have people talk about the cost of doing nothing, so that he can understand in economic terms that we're talking about saving money and not busting budgets.

This could be one of the most exciting things that Bill Paxon and I have been involved in because it will take more than legislation; it will take building up a groundswell of support. And if those polls are right, it will not be nearly as difficult as we have thought.

And now, from the Administration, Dr. Elaine Johnson, who has worked before with this committee. Dr. Johnson has worked as the director of the Office for Substance Abuse Prevention since 1988, and has been deputy director of the National Institute of Drug Abuse; and she was responsible for directing many of NIDA's drug treatment programs in the 1970's and the early 1980's; and certainly has been someone committed personally and professionally to try to find solutions to these problems.

So, Dr. Johnson, I hope you, too, might think of the people in the Administration that we in the Congress can invite to listen to the pleas of those in and out of the Administration that have to work together if we're going to find any answers to the complex problems we're facing.

You've always been there when we needed you and thank you for responding once again.

Dr. JOHNSON.

STATEMENT OF ELAINE M. JOHNSON

Dr. JOHNSON. Thank you, Mr. Chairman, and good morning. I certainly will be very happy to participate with my colleague, Dr. Beny Primm, in helping to identify people, especially in government, that can participate in that forum.

I am further delighted to have the opportunity of participating again in the annual Congressional Black Caucus weekend program.

I appear before you today to talk on the vital issue of drug-exposed children, a problem which is having a serious impact on many segments of our society, particularly on our health care and educational systems, as many of our presenters have already indicated.

As director of the Office for Substance Abuse Prevention, I have witnessed firsthand the devastating effects of alcohol and other drugs on children born to substance-abusing parents.

I would like to present to you today information that will, hopefully, add to your understanding of the issue and describe OSAP's efforts to combat this tragic aspect of America's continuing drug problem.

OSAP's main goal in addressing the issue of drug-exposed infants is to promote effective prevention, early intervention, and treatment efforts that provide women of child-bearing age the necessary support and knowledge to maximize their opportunity to have drug-free children.

Second, for those children who have been drug-exposed, our goal is to develop effective comprehensive programs addressing the needs in the early stages of development with a view toward helping these youngsters develop healthy and productive lives.

It is through this comprehensive approach of balanced prevention and treatment activities that we believe there will be the greatest progress.

With the creation of OSAP in 1986 and the establishment of the High-Risk Youth Demonstration Grant Program, OSAP began to address the critical issue of drug-exposed children. Children of substance abusers and youths under the age of 21 who become pregnant are included as categories of high-risk youth. Programs such as the one formerly directed by Dr. Primm in New York City receive funding under this program.

Due to the fact that children of substance abusers face multiple problems, OSAP has sought from the very beginning to fund programs that provide youths with a set of comprehensive services to address their numerous needs.

In 1988, OSAP was authorized to initiate a demonstration program for Pregnant and Postpartum Women and Their Infants. The purpose of this program is to demonstrate the effectiveness of model projects for this population. The projects are family-oriented service programs, intended to act as models for future replication.

OSAP's programs in this area provide for various interventions, including comprehensive prenatal services, drug counseling, HIV education and screening, followup and tracking after delivery to make sure that the mother keeps her clinic appointments and her child's appointments, and followup for the infant, including developmental assessments and referral to special services.

Other current strategies being tested in the program include training to improve parent-child bonding, enhancing of parenting skills to assist parents to better deal with drug-exposed children, screening of pregnant women for past and present alcohol and other drug use, and developing innovative methods of outreach to identify and recruit the target populations for services, preferably in the early stages of pregnancy.

For example, staff of OSAP-funded projects attend block association meetings, canvas public housing sites, set up information tables during rent payment times, and network with other agencies that have contact with pregnant women.

The first awards under the pregnancy program were made in September of 1989. In fact, this committee is familiar with one of our grantees, Dr. Charlie Knight, from testimony at your last hearing on this subject and again today.

By the end of fiscal year 1991, we expect to have 131 Pregnant and Postpartum Women and Their Infants projects operational.

Aside from these two major demonstration grant programs that deal directly with pregnant women and their infants and children living in high-risk environments, OSAP has recently embarked on another effort which we feel will have a tremendous impact in the field of perinatal addiction prevention.

A few weeks ago, Secretary Sullivan, of the Department of Health and Human Services, formally announced the establishment of OSAP's National Perinatal Addiction Prevention and Technical Assistance Resource Center. Under a $5 million per year contract, the Resource Center will focus on improving the quality of health, education and social services being offered to pregnant women, new mothers and their children.

I would also like to mention OSAP's first Issue Forum, held last November, which focused on drug-exposed children aged 2 to 5. OSAP addressed this topic because early findings had indicated that drug-exposed toddlers may need a significant degree of special care to help them physically and psychologically prepare to enter the public school system of this Nation.

I can assure you, Mr. Chairman, that OSAP has taken seriously its role in responding to the congressional mandate to design and implement programs for children and others at risk for substance abuse. OSAP's ongoing prevention activities reflect a commitment to meeting the needs of this population in a very aggressive manner. We will continue to expand and enhance our agreements with appropriate Federal offices that will help achieve a well-balanced Federal program.

We know that children born drug-exposed are treatable and teachable. We also realize that comprehensive prevention and treatment efforts which address a variety of social problems contributing to substance abuse are the key in achieving drug-free births.

Thank you again, Mr. Chairman, for the opportunity of appearing today, and I look forward to our discussion following this morning's panel presentation.

[The statement of Dr. Johnson follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Alcohol, Drug Abuse and
Mental Health Administration
Rockville MD 20857

STATEMENT BY

ELAINE M. JOHNSON, PH.D.

DIRECTOR

OFFICE FOR SUBSTANCE ABUSE PREVENTION

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PUBLIC HEALTH SERVICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

UNITED STATES HOUSE OF REPRESENTATIVES

SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

September 13, 1991

9:30 a.m.

Room 1100

Longworth House Office Building

Release Only Upon Delivery

Mr. Chairman and Members of the Select Committee:

I am pleased to testify before you today on the vital issue of drug-exposed children, a problem which is already having a serious impact on many segments of our society, particularly on our health care and educational systems. As Director of the Office for Substance Abuse Prevention (OSAP) in the Alcohol, Drug Abuse and Mental Health Administration, I have witnessed first-hand the devastating effects of alcohol and other drugs on children born to substance abusing parents. I would like to present to you today information that will promote an understanding of the issue and describe OSAP's efforts to combat this tragic aspect of America's continuing drug abuse problem.

OSAP's main goal in addressing the issue of drug-exposed infants is to promote effective prevention, early intervention, and treatment efforts that provide women of childbearing age the necessary support and knowledge to maximize their opportunity to have drug-free children. Secondly, for those children who have been drug-exposed, our goal is to develop effective comprehensive programs addressing their needs in the early stages of development with a view toward preventing dependence or involvement with drugs later in life. It is through this comprehensive approach of balanced prevention and treatment activities that we believe there will be the greatest progress.

With the creation of OSAP in 1986 and the establishment of the High-Risk Youth Demonstration Grant Program, OSAP began to address the critical issue of drug-exposed children. Children of substance abusers and youth under the age of 21 who become pregnant are included as categories of high-risk youth. Children of substance abusers are one of the highest risk groups for substance abuse. Studies have found that offspring of alcoholic parents often exhibit cognitive and interpersonal problems as children and also have shown that parents and siblings use of illicit drugs increases a youth's risk of alcohol and other drug use.

Due to the fact that children of substance abusers face multiple problems, OSAP has sought from the beginning to fund programs that target youth with multiple risk factors, and propose comprehensive, multilevel prevention/intervention strategies that address clearly specified risk factors. Some of the risk factors that OSAP's High-Risk Youth grantees are concerned with include failing academic performance, parents who present poor role models, gangs operating in schools, lack of substance abuse and health information curriculum in schools, and lack of pride and responsibility for the neighborhood or local community.

Strategies and interventions utilized by grantees to deal with these risk factors and increase resiliency factors might include peer tutoring to improve academic performance; programs of parental skill building in communications and discipline; cultural enrichment programs; mentoring; vocational planning and guidance; instituting substance abuse and health curriculum in schools, including AIDS prevention; and after school and school associated clubs, sports, games, and recreation to increase school bonding.

Another important component of our High-Risk Youth program, as well as our Pregnant and Postpartum Women and Their Infants Program discussed below, is a rigorous evaluation. The purpose of the evaluation is to assist programs in discarding ineffective strategies and pursuing the development of strategies that are promising with respect to both implementation and outcome. The initial funding of the high-risk youth program ($24 Million) supported 130 grants. At the end of fiscal year 1991, the program will have approximately 148 grants operational.

The Anti-Drug Abuse Act of 1988 authorized the initiation of a demonstration program for Pregnant and Postpartum Women and Their Infants (PPWI). The purpose of this program is to demonstrate the effectiveness of model projects for substance-using pregnant and postpartum women and their infants. The projects are client-oriented service programs, intended to act as models for future replication. OSAP plans to develop a strategy to enable the continuation of those federally sponsored projects showing a high rate of success and replicability.

The Maternal and Child Health Bureau collaborates with OSAP in the planning and implementation of the PPWI activities by detailing a staff person to work with OSAP and transferring funds to OSAP for the support of this program. The PPWI program has allowed OSAP to specifically target the wide array of consequences of maternal use of alcohol and other drugs on offspring and to meet the health and psychosocial needs of women who use alcohol and other drugs during pregnancy.

As with children of substance abusers, pregnant and postpartum women and their infants have varied and complex needs, which must be addressed comprehensively through a combination of prevention, early intervention, and treatment approaches. The case manager, who can coordinate a multiplicity of social services for the client, is a critical element of an effective PPWI program. Some of these social services include unemployment/welfare, child protection, and assistance in locating drug-free housing. In addition, case managers often times act as a liaison to the courts and law enforcement agencies.

Some of the current strategies being tested in the PPWI program include training to improve parent-child bonding; enhancing of parenting skills to assist parents (particularly mothers) better deal with drug-exposed children; screening of pregnant women for past and present alcohol and other drug use; and developing innovative methods of outreach to identify and recruit the target populations for services, preferably in the early stages of pregnancy.

OSAP also recognizes the fact that in many communities, existing services are inadequate or even non-existent. Where such gaps exist OSAP encourages applicants to propose the following types of projects: coordination and integration of existing services; outreach, including the identification of the target populations and encouragement (i.e. social and logistical support) for provision of services; financial and other incentives that increase the accessibility and acceptance of services; augmentation of existing services (i.e. the addition of prenatal and/or postpartum care to drug treatment programs); and the creation of new comprehensive services. The comprehensive services delivered through PPWI grants allow the initiative to truly take a preventive approach by addressing some of the underlying causes of drug addiction (such as poverty and lack of education).

The first awards under the PPWI program were made in September 1989. (In fact, this Committee is familiar with one of our PPWI grantees from testimony at your last hearing on this subject and again today.) By the end of fiscal year 1991 we expect to have 131 programs operational. Our data from the first year of this grant program's operation show that approximately 6,000 women and children have already been direct service recipients, and that approximately 25,000 people participated in grantee sponsored events. After the grants from fiscal year 1991 become fully operational, we expect the grantees to be capable of providing services to approximately 15,000 women and infants.

Substance abusing women face many barriers to drug treatment. For instance, many treatment programs do not accommodate the children of addicted women. Furthermore, many women are reluctant to seek treatment for fear of losing custody of their infants and children permanently. Therefore, OSAP is working towards providing heightened emphasis on residential treatment which provides for keeping addicted women and their children together.

It is clear that where women are allowed to have their children with them during treatment, they tend to remain longer in a more positive environment and, therefore, increase their chance of recovery. Additionally, the program is able to provide direct prevention, intervention, treatment, and services for the children. Keeping the mother and child together as a unit confers benefits to both of them and assists in promoting strong maternal-child attachments.

Aside from these two major demonstration grant programs that deal directly with pregnant women and their infants and children living in high-risk environments, OSAP has recently embarked on another effort which we feel will have a tremendous impact in the field of perinatal addiction prevention.

A few weeks ago, Secretary Sullivan formally announced the establishment of OSAP's National Perinatal Addiction Prevention and Technical Assistance Resource Center. Under a $5 million per year contract, the Resource Center will focus on improving the quality of health services being offered to pregnant women, new mothers, and their children. By convening experts, providing training, offering technical assistance services to community programs, conducting field assessments of data collection systems, promoting information exchange on successful programs strategies, and developing a national learning network of experts and practioners, the Resource Center will provide national leadership in fostering creative approaches to alcohol and other drug abuse prevention and enable OSAP to continue to expand its efforts in addressing the needs of these populations.

I would also like to mention OSAP's first Issue Forum, held last November, which focused on drug-exposed children ages to 2 to 5. OSAP addressed this topic because early findings indicate that drug-exposed toddlers may need a significant degree of special care to help them physically and psychologically prepare to enter the public school system. The purpose of the Forum was to formulate a series of recommendations that would help guide OSAP in the development and promotion of research-based national

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programs that will assist pre-school children, exposed in-utero to drugs, including alcohol, in developing to their maximum potential. In addition, these recommendations are intended to help health care, early development, and education professionals in their planning of prevention and early intervention services for these children. We anticipate that the monograph from the Issue Forum will be available in 3 to 4 months and would be very pleased to share it with the Committee.

I can assure you, Mr. Chairman, that OSAP has taken seriously its role in responding to the congressional mandate to design and implement programs for children and others at risk for substance abuse. OSAP continues to strive to implement the most effective practices in strengthening future service and research efforts aimed at the prevention of substance abuse among pregnant women as well as minimizing the effect of maternal alcohol and other drug use on the infant and young child. OSAP's ongoing prevention activities, such as the PPWI program, and the new efforts, such as the Perinatal Resource Center, reflect a commitment to meeting the needs of this population in a proactive manner.

OSAP intends to meet the future with sound data and experience from our demonstration programs. With this in hand, we can take the comprehensive approach we have required in our client and systems-oriented programs, and utilize it at the Federal level.

We want to establish more inter and intra agency agreements with appropriate offices that will help achieve a well-balanced Federal effort. Within our own Department we work with the Administration for Children and Families, including the Head Start Program, through sharing technical information via workgroups on gang violence and through publishing a series of training manuals for teachers, parents, and children. In addition, we work together with the Health Resources and Services Administration in our pregnancy program and in developing a primary health care provider curriculum for substance abuse. We also have working relationships with such agencies as the Department of Education and the Department of Housing and Urban Development, and we see the necessity to expand upon these collaborative efforts.

We know that children born drug-exposed are treatable and teachable. We also realize that comprehensive prevention and treatment efforts which address the variety of social problems contributing to substance abuse are the key in achieving drug-free births.

Thank you again, Mr. Chairman, for this opportunity to testify today. I would be happy to respond to any questions you or the Committee Members may have regarding my statement.

Mr. **Rangel**. Thank you so much, Dr. Johnson.

I don't think that Beny Primm needs any introduction; certainly he has given 30 years of service to the city of New York in the area of treating addicts and he's certainly been a national treasure in terms of expertise in advising and directing the mission of our Federal Government.

I'm so glad that he is the wrapup person for our panel because he would know the elements that would need to come together on the local, State, and Federal level, as well as the private sector, to make certain whether we have the political courage to do what has to be done; at least we will be able to say that we brought together those key players in our Nation that have developed expertise in this area. And certainly in the area of treatment, there's no one that comes near the expertise that Beny Primm has.

Thank you, Dr. Primm.

STATEMENT OF BENY J. PRIMM

Dr. **Primm**. Mr. Chairman, I want to thank you for that introduction. I'm terribly flattered by it. When you hosted my reception, when I came to Washington, here on Capitol Hill, you made some of the same statements, and I hope in the last 2 years, since the 19th Congressional Black Caucus took place, that I have served you well.

I'd like to say hello to Mr. Paxon and you and the members on the dais, thank you for inviting me and tell you how proud I am to be here.

The first issue I'd like to discuss is your analogy of the drug war to Desert Storm, and the level of effort we put into Operation Desert Shield and then Operation Desert Storm.

Let me say that I feel, just like you do, that the analogy is a good one. We need the same zeal, the same kind of vigor and commitment in the drug war that we had for Desert Shield and Desert Storm.

We've not yet begun to do that. I think we are, of course, winning some battles throughout the country. We are, in a sense, improving the quality of drug treatment throughout the country, and we need a little bit more time before we'll have a full-blown victory like we witnessed in Desert Storm.

I also want to discuss some topics I feel are really important. Mr. Timpane and Bob Chase talked about the issues of training personnel and teachers. Additionally, we also need training of physicians, social workers, nurses, and all the support service staff.

We have a tendency to focus on the negative things that have happened. And as a consequence, we don't look at some of the very positive issues that are taking place; of the positive things that are taking place in my office and Dr. Johnson's office.

I consider the office that I head to be a part of the executive and legislative branches of Government. The Congress certainly authorizes and appropriates the dollars that I spend, so I belong to them. And not only do I belong to them, Mr. Chairman, I belong to you because I have a program in the 16th Congressional District.

So when I talk today, I'm going to talk about our programs, which means your programs, too, because your tax dollars are the ones that Congress appropriates for me to give back to you for certain programs that are designed by the Federal Government.

First of all, we all know that pregnant and drug-dependent mothers are at risk for numerous health problems. They share unclean needles and other drug-using paraphernalia. This puts the drug-injecting woman at a risk of acquired immune deficiency syndrome [AIDS], and hepatitis.

The addicted woman is frequently sexually active and, therefore, is at an increased risk for sexually transmitted diseases such as gonorrhea, syphilis, herpes, and other viral infections that are just as mortal as drug addiction itself—even more mortal.

Addicted women are often poorly nourished. They do not seek prenatal care for fear that their addiction will be found out and that they will be prosecuted for it. These women frequently suffer premature labor and give birth to babies with very low birth weight.

Our programs are designed to do something about these problems. For the drug-dependent woman who is typically without any resources or support systems, treatment outcome is best assured through a provision of comprehensive—and I want to emphasize "comprehensive"—array of treatment services that address a full range of bio-psycho-social needs.

And I talk about bio-psycho-social needs because these women have each one of these things in great numbers. Biologically, they are pathological; psychologically they are also pathological; and socially, they have suffered so many social dislocations that it's almost impossible to treat them without focusing on all three of these things.

They need appropriate comprehensive care that includes primary health care. Primary health care is important in order to get these women in good health. They need prenatal services. They need mental health services. They need addiction treatment interventions coupled with a wide array of social services—educational and vocational.

They also need some education on how to take care of other members of their family. They have generally lost the ability to even do that.

I think these services should be delivered in a one-stop shopping kind of approach—a supermarket of services, if possible, in one location, so that you don't have to send these individuals across town to get their social services or down the street to get their mental health services.

A one-stop shopping situation is ideal. Most places don't have this kind of program. If you don't have this kind of program, a formal one must be created in order to deliver the kinds of services that are needed.

The Office for Treatment Improvement—my office—administers the alcohol, drug abuse and mental health [ADMS] block grant, which is the primary tool by which the Federal Government supports all the States' treatment efforts on a nationwide scale.

In fiscal year 1991 about $1.2 billion of ADMS dollars were available to the States. About 10 percent of that $1.2 billion is appropriated by congressional statute, to be spent on treatment for women—about $120 million. Each State must spend that.

We are now in the process of looking at States to make sure that they have taken care of that commitment to be compliant with the wishes of Congress.

OTI, in conjunction with experts that come from outside of government—extramural experts—have set up what we call "how to guidelines" to treat pregnant women. We call these TIPS, or treatment improvement protocol statements, which is sort of a cookbook that is being put into print by outside experts and intramural experts on what to do—what are the best interventions for this population.

I'd like to point out, Mr. Chairman, that these TIPS will also tell people how to enhance treatment, how best to do that, including the church, the American Medical Association, the National Medical Association, and how to link the primary health care system with the substance abuse delivery system.

Through our Target Cities efforts, we have chosen eight cities throughout the United States—Boston; New York; Baltimore; Atlanta; San Juan, Puerto Rico; Milwaukee; Albuquerque; and Los Angeles, and are assisting them in setting up a better delivery system. Each one of these cities has received a considerable amount of Federal dollars to set up an ideal system to deliver better services.

Through that system, we are working with the Administration of Children, Youth and Families with the Head Start Program to coordinate efforts of Head Start with our drug treatment efforts.

My office also has produced two reports recently on Medicaid financing of alcohol and drug abuse services. One report, a statewide survey, of eligibility coverage and services for children and adolescents is being published.

We will be looking at 20 States each year for the next 3 years until we look at all 50 States and the 8 territories that we fund, to make sure that they are using the tax dollars the way they said they were going to do.

We also are helping them with the epidemiology, that is, with the incidence and prevalence that goes on in their States, so that they'll have a better handle on what's happening.

Our office is providing funds through the Office of Population Affairs to train family planning clinic personnel in the detection, referral, and treatment of addictive disorders in women and children who present for treatment in family planning clinics. So we're reaching out to Head Start and also to family planning clinics.

We're reaching out to women in their communities providing grant funds for the establishment of one-stop treatment centers within adjacent buildings to public housing units throughout the country. We just awarded yesterday a number of public housing grants where we go into public housing, do prevention, education, and set up treatment and talk about early recognition of problems.

We're also working with the Department of Housing and Urban Development to bring about a more comprehensive drug treatment approach in public housing throughout the country.

We have set up programs within the corrections system. We fund a prison program in the State of New York at Bedford Hills, Mr. Chairman, where women who are pregnant can be with their babies while in prison; and before they're discharged, the program teaches them how to be better parents.

So we are well on our way to establishing a preparation very similar to Desert Shield. We're certainly not in Desert Shield yet, but we're well on our way.

I would like to also say to my colleagues this morning, many of whom have talked about Federal leadership, that Federal leadership is the answer.

Mr. Chase talked about the Federal leadership not being enough; your leadership, people in the community, congressional leadership, whatever we can get is needed also. People from every branch of Government should be involved in this problem because it's that serious.

When we talk about Federal leadership, I'm part of that leadership and I've committed myself to it. What I'd like to think, from my many years of experience in this field, is that what we are doing in the Office for Treatment Improvement can do something to turn around this problem. And as long as I stay here, I'm going to try to do my darndest to make things better.

I want to thank you this morning, Mr. Chairman, for the opportunity to share these few insights that I have. This concludes my testimony, and I'd be glad to answer any questions that you may have.

I want to leave you with one thought, however. Treatment works. We also heard Mr. Timpane say that prevention works. We can look at prevention and education when it comes to the use of cigarettes. In 1960, 50 percent of the American population smoked cigarettes. In 1990, only about 30 percent smoke cigarettes. We know that prevention and education made a tremendous impact.

We can do the same thing with drug abuse. We are seeing an impact, particularly in the minority community among young black high school seniors. This population smokes far less than their white counterparts. Prevention and education have been effective in that community and I think it can be effective for other drugs too.

Thank you very much, Mr. Chairman.

[The statement of Dr. Primm follows:]

STATEMENT OF

BENY J. PRIMM, M.D.

ASSOCIATE ADMINISTRATOR FOR TREATMENT IMPROVEMENT

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

PUBLIC HEALTH SERVICE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

HOUSE SELECT COMMITTEE ON NARCOTICS ABUSE AND CONTROL

September 13, 1991

RELEASE ONLY UPON DELIVERY

Mr. Chairman, members of the Select Committee, I am Dr. Beny Primm, Associate Administrator for Treatment Improvement in the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). The Office for Treatment Improvement (OTI) is charged with providing leadership for our national effort to improve substance abuse treatment. To accomplish this goal, OTI works with the research institutes within ADAMHA and with other Federal agencies to identify effective treatment methodologies for addiction. Additionally, OTI provides financial and technical assistance to States in order to facilitate the transfer of efficacious addiction treatment technologies.

I would like to thank you for inviting me to testify before you today on the devastating subject of drug-exposed children. It is one of my great fears that unless we do something quickly for these substance abusing women and their children we will have a generation of damaged Americans with all types of physical and psycho-social problems which will tax our health care and education systems for years to come. I would like to speak to you on an important first step toward preventing pre-natal drug exposure - treating pregnant women and getting them drug free before their baby is born.

Addiction is a chronic, relapsing disorder that encompasses a host of physical, psychological, and sociological problems. For the drug-dependent woman, who is typically without any resources or support systems, positive treatment outcome is best assured by a comprehensive array of treatment services that address her medical, psychological, emotional and environmental needs.

It is well known that the physical problems encountered by the pregnant drug dependent mother are enormous. Sharing unclean needles puts the IV drug using woman at risk of HIV infection and hepatitis. The addicted woman is frequently sexually active, and therefore is at increased risk for sexually transmitted diseases such as gonorrhea, syphilis, herpes, and HIV infection.

Addicted women are often poorly nourished and do not seek prenatal care. These women most frequently have premature labor and give birth to babies with very low birth weight. A recent study published in the Journal of the National Medical Association found that 85% of Black infant deaths in Washington, DC were attributed to "prematurity and related conditions." This study estimated that seventy-one percent of all Black infant deaths are preventable.

Medical services for pregnant drug dependent women must encompass the perinatal and pharmacological, as well as health, alcohol and drug education, and appropriate referral. These services must include HIV counseling and testing, and nutritional counseling.

The mother should deliver in a hospital where a full range of services are readily available in case of complications in the delivery.

For opiate dependent pregnant women, there is an effective treatment that also can help reduce the risks of sexually transmitted diseases and the delivery of drug impaired infants - methadone maintenance. It is clear from the scientific research that the therapeutic use of methadone in a comprehensive maintenance program is safe for the pregnant woman and her unborn child. OTI is currently working with state alcohol and drug abuse agencies, narcotic addiction treatment providers, and experts in the field of narcotic addiction and methadone maintenance to establish technical assistance guidelines for the use of methadone, including a section on treating the pregnant addict. These guidelines are expected to be available in the field by the Spring of 1992.

THE OFFICE FOR TREATMENT IMPROVEMENT'S EFFORTS TO IMPROVE TREATMENT SERVICES FOR WOMEN AND INFANTS

In OTI, we are actively pursuing several initiatives to improve treatment delivery for substance-exposed women of childbearing age and their children.

- OTI administers the Alcohol, Drug Abuse, and Mental Health Services (ADMS) block grant, the primary tool by which the Federal government supports States' treatment efforts on a nationwide scale. In FY 1991, approximately $1.2 billion was available to the States and territories through the ADMS block grant.

  Congress has legislated a set-aside within the ADMS block grant which requires states to use at least 10 percent of their allocations for alcohol and drug abuse programs which serve women, especially pregnant women and women with dependent children, and for demonstration projects designed to provide residential treatment services to pregnant women.

- As part of its State Systems Development Program (SSDP), OTI plans to provide targeted technical assistance to the States in a number of critical areas such as: assessment of incidence and prevalence, access to treatment, patient-treatment matching, and management and coordination of a variety of health and human services for perinatal women. The SSDP is scheduled for implementation in FY 1992.

- OTI, in conjunction with Federal and National experts is producing a series of Treatment Improvement Protocol Statements, known as TIPS, which will serve as guidelines to the ADMS Block Grant funded programs.

These guidelines and standards of care are intended to provide States with state-of-the-art information for establishing, funding, monitoring, and evaluating programs. These guidelines will cover subject areas as assessment; substance abuse treatment services, relapse prevention and aftercare; medical services; mental health services; life skills management; sociocultural and demographic aid; parenting skills and early childhood development.

One of the initial TIPS presently being developed is for the treatment of pregnant, substance-abusing women and their families.

o OTI, through its Target Cities Program, and in collaboration with the Administration of Children, Youth and Families' Head Start Program is assisting families involved with drug abuse in eight cities: Boston, New York, San Juan, Atlanta, Baltimore, Albuquerque, Milwaukee and Los Angeles/Long Beach.

The sum of $100,000 per year for three years will be available to the Head Start grantees located in the OTI funded Target Cities to: (1) improve access to substance abuse treatment services for Head Start families; (2)

develop joint training programs for Head Start staff for early identification of, and intervention with, families involved in the abuse of alcohol and other drugs; and (3) develop joint case management strategies between Head Start and Target Cities staff. This Target Cities/Head Start Initiative will help to provide children with the specialized services they need in order to succeed in school.

o OTI's Division of State Assistance has recently produced two reports in the area of Medicaid financing of alcohol and drug abuse services. One report, a survey of State eligibility coverage and services for children and adolescents, is in print. The other is a handbook for State Alcohol and Drug Abuse Agencies that are interested in working with their State Medicaid Agencies to broaden the base for treating alcohol and drug dependent individuals, especially pregnant women. This report is currently in the review process.

o Another one of OTI's projects, The Primary Care/Substance Abuse Linkage Initiative, will help strengthen the collaboration between primary health care providers and the alcohol, drug abuse, mental health and HIV treatment systems. The Primary Care/Substance Abuse Initiative will provide a forum to explore access to comprehensive treatment for pregnant women in need of primary health care, drug abuse, alcohol and HIV treatment services. A special workgroup was formed to address minority family health care issues including pregnant addicts, and infants. A National Conference is to be held here in Washington February 26-28, 1992.

o Additionally, OTI provided $500,000 to the Office of Population Affairs (OPA) to enhance training of family planning clinic personnel in drug abuse and service to drug abusing clients. The OPA will award supplemental grants to OPA Regional Training Centers to provide training to family clinic staff on how to: (1) identify signs of drug abuse; (2) provide improved family planning services to drug abusing women; (3) facilitate the entry of drug abusing clients into treatment programs and; (4) provide preconception counseling on the risks of drug and alcohol abuse for women and their children.

OTI has several demonstration programs which directly or indirectly serve perinatal women and their children. These include: 1) Cooperative Agreements for Drug Abuse Treatment Improvement Projects in Target Cities; 2) Model Comprehensive Treatment Programs for Critical Populations; 3) Model Drug Abuse Treatment Programs for Correctional Settings; and 4) Model Drug Abuse Treatment Programs for Populations Diverted from

Incarceration within the Criminal Justice System; and 5) The Drug Abuse Campus Treatment Project.

(1) The Target Cites program provides financial and technical assistance to eight State-selected urban areas identified as having a high prevalence of drug abuse. The program supports activities designed to overcome the barriers to interagency coordination and cooperation, improve the delivery of treatment services, and strengthen the drug treatment infrastructure by providing training and other technical assistance.

(2) Under the Critical Populations program, OTI provides resources to treatment providers which target services to at-risk populations: 1) racial and ethnic minorities; 2) adolescents and; 3) residents of public housing. This program seeks to ensure that patients are offered a complete array of addiction, health, mental health, education, vocational training, and social services, including welfare.

A total of 90 grants support a wide array of services, such as: enhanced outreach, provision of on-site primary medical care, staff training, educational counseling, and AIDS education, testing and counseling. Of the programs funded, nine specifically treat pregnant and/or postpartum women and their infants.

(3) OTI's Model Drug Abuse Programs for Correctional Settings permit incarcerees to participate in a comprehensive treatment program. Nine States were awarded three year grants under this program, in FY 1990. The State of New York is utilizing their grant award to establish a treatment program for pregnant incarcerees which will allow them to retain custody of their infants during incarceration.

(4) Under the Model Drug Abuse Treatment Programs for Non-Incarcerated Populations, a total of 10 States were awarded three year grants under this program FY 1990, all of which focus upon improved policies and procedures for diversion of arrestees into treatment in lieu of incarceration, better treatment-patient matching, and long-term follow-up and aftercare.

(5) The Campus Treatment Project involves cooperative agreements between States and OTI to create a setting where several providers, sharing common resources, deliver residential treatment services for drug abuse. All campuses must focus on the treatment of one or more of the following populations: racial and ethnic minorities; pregnant women; female addicts and their children; or adolescents. The evaluation of the campus project will be performed by the

National Institute on Drug Abuse (NIDA).

The Target Cities, Critical Populations and Criminal Justice grantees will participate in the National Treatment Evaluation Study. This evaluation is being designed to determine program impact on individual treatment outcome and upon the community at-large. The national evaluation is designed to spotlight effective treatment methods that will serve as models for national replication.

REMAINING BARRIERS TO EFFECTIVE TREATMENT

In order to address the remaining barriers to efficacious treatment for substance-abusing women and substance-exposed infants, we must continue to approach the problem rationally and compassionately. Addiction is a chronic relapsing disorder which is exacerbated by a host of social and economic dysfunctions.

To combat this problem, we must work at all levels - Federal, State, community, public and private - to encourage these women to seek treatment and to provide them with the support services they and their families need in order to break the cycle of intergenerational addiction, child abuse, and educational and economic hardship.

OTI plans to continue to maintain its leadership role by assisting States and communities to:

- Identify and implement effective treatment methods for women and infants.
- Ascertain the extent to which demand for treatment exceeds existing treatment capacity and develop the resources necessary to fill existing gaps in the treatment delivery system for women and infants.
- Coordinate service delivery among a wide array of health, housing, education, social security, and other human services agencies, to create a "safety net" for women and their children.
- Reduce existing barriers to treatment by cultivating the concept that treatment works.

We must also examine existing social institutions for ways in which to encourage, rather than discourage, self sufficiency and self esteem for women and children who are particularly at-risk for addiction. The juvenile justice and criminal justice systems, often a first point of contact for young women who are involved with drugs, must work more closely with treatment and social service agencies to develop diversion-to-treatment programs for first-time female and juvenile offenders whose primary problem is substance abuse. Law enforcement and courts, social workers, employers and educators must be trained to identify women and children who are particularly at-risk for addiction and link these individuals and/or families with the treatment and support services they require.

In conclusion, over the past several decades, appropriate treatment techniques for pregnant and/or postpartum drug dependent women have been researched and developed. We are fortunate to have a pharmacological agent (methadone) that has been shown to be efficacious for opiate dependence, not only in the initial stages of pregnancy but in on-going therapy following birth.

While there is no pharmacological agent found to be effective in the treatment of pregnant and/or postpartum women addicted to cocaine, it is possible to greatly enhance maternal and infant outcomes by combining medical, psychological, sociological, economic, mother-infant development, and early childhood interventions. Moreover, with the provision of comprehensive services, we are able to provide treatment that will rehabilitate the mother not only during pregnancy but in the postpartum period, so that she may bond with her infant and continue the maternal-infant relationship. By treating the mother, we also help her child, thus ensuring that future children born in this

Nation will not be plagued by the pain, physical and psychological disabilities, and sociocultural dislocations that often accompany addiction.

Mr. Chairman, I will be pleased to answer any questions that you or the other members of the committee may have.

Mr. **Rangel.** Thank you.

That's the note that we want to leave the formal part of our program on. We will now open the panel to ask each other questions or receive questions from the audience. You distinguished people in the audience have come to listen to us; if you have prepared questions we will move into that.

But I'd like to summarize the commitment that the Chair has made and will receive written suggestions from you before we depart.

Beny, I would like to take those targeted cities that you were talking about and use that as an example to show what the Administration is doing. And at the same time, see if I can pull out of those cities professionals that have developed the expertise in dealing with the problem, because I think Mike's candor allows all of us to say that: Heck, I didn't know you were doing those things.

So why don't we find those people who know what's being done in a positive way and also trained to understand it better than those who are trained to get elected to see whether we can bring that expertise to a larger forum; so that those of you who are providing something can share with other people who know that they need more but may not know how to articulate what they actually need.

If we can put this in a way that we're not asking the Federal Government to assume the responsibility of education, but perhaps to realize that we're going to have to target where these epidemics are growing to prevent them from spreading because my chief of staff has just shared with me that his kid doesn't go to a ghetto school, but is seeing the impact in the classrooms and feeling the responses from the teachers that this is now moving into other areas the same way that every crisis that a nation faces does. A crisis like this does not contain itself within the walls of a so-called inner city ghetto.

So I will be sending to you, individually, what I think has come out of this conference for your approval, additions, changes. I will include not only what you do—and we'll need more information—but what you have shared with us so that when the call goes out that we will have a comprehensive information bulletin; they won't come here just to say what they need. They have a better understanding as to what programs are working.

And you would be able, Bob, to share with your board what we're trying to do. We might need some union people here. We might need some superintendents here. We might need some teachers here. But certainly I think we could set aside a date to start in the morning to have a large table with the understanding that when we leave we want to have a plan and a strategy.

And if we give the participants enough time to prepare so that everyone would know, Beny, that we're not here to criticize or embarrass, but to see what we can come up with. Perhaps we can get some ideas by mail and phone that would eliminate a lot of conflict that normally arises when people are trying to decide turf and the restrictions that they have on budget.

I promise you that I will take advantage of the personal relationship that I have with Dick Darman, who is the director of the Office of Management and Budget, to share with him that we're not here to bust budgets; we're here to save dollars as well as human lives.

I also will produce for you those national leaders that have come here begging for the type of support we've been discussing. The National Association of Manufacturers, the National Economic Roundtable, and the New York City Partnership, for example, could bring the type of support that even the administration looks forward to every 4 years. So we'll be able to do that.

Dr. PRIMM. Mr. Chairman, I had one other thing to add to the target cities piece, and I'm happy you focused on that because we're very proud of that.

We also, in those target cities and throughout the country, give critical population grants. These critical population demonstration grants are targeted to individuals rather than the system itself, to make things better for them.

We target minorities, pregnant women and their offsprings, people who live in public housing and, of course, those people who are involved in the criminal justice system. All four of those help to enhance and make the quality of treatment far better. I wanted to add that so that the panel and the audience will know that.

We have 100 such demonstration grants out presently. And we will be continuing them in 1992.

Mr. RANGEL. Thank God, the question of quotas and affirmative action are not raised when it comes to the victims, because we really would be in trouble if we had to avoid targeting special treatment in that area.

In any event, now is the time for those who have any questions to proceed to the mike, and also for the panelists, if they have questions of each other, or the role of Congress in this, to have this open part. You can direct your question to any or all of the panelists but please identify yourself so that we would do our best to respond.

Mr. ARTHUR JOHNSON. My name is Arthur Johnson. I'm from East St. Louis, IL. I represent the Metro East Church-Based Citizens Organization, which is 24 churches in East St. Louis.

My question is to Dr. Beny Primm and Dr. Johnson. I picked up a lot of good things. I'm also an adolescent youth drug counselor, too.

Treatment has gotten to be a big business in America. There are a lot of companies and health providers that are making a lot of money off treatment. East St. Louis is a city which is 97 percent black. We've got a population of 50,000 people—a little under 50,000 people. We have one hospital. The general population is basically on welfare.

There's only one treatment facility in East St. Louis. There's only one prevention provider in East St. Louis that is funded through the State.

Recently, the State, in the last 10 years, has created a number of entities around East St. Louis to serve East St. Louis. One of them has been an adolescent youth facility which I work at, and it has a $20 million grant to service the kids of East St. Louis. However, it only services about 1 percent of this population.

I hear you saying, Dr. Primm, that you should give the States responsibility and give them money to deal with the most distressed areas. However, the State of Illinois, in this instance, hasn't been doing that.

Now the Governor of the State of Illinois is screaming, it's the money, we need a budget cut. And we're already suffering the hardest. We've got the highest—in 1989, we led the capital in murder, you see. We've got the highest drug problem in the whole State, and still we get the least amount of treatment according to the State, where the State does this.

What kind of mechanism will you put in assuring that the State will service the most distressed areas?

Mr. **Rangel**. Let me interrupt. I think that's a very, very good question. It took you a long time to get to the question and I hope that the other questioners might get to that bottom line because we will not be able to service particular organizations and communities.

But I am glad that the question you raise is, how will the States be held accountable for the funds that are available for communities such as yours that are in need?

Dr. Primm?

Dr. **Primm**. Let me respond by saying, all the money that comes out of my office flows through the State to the provider that has made application for those dollars in my office. I want you to understand that.

Now, East St. Louis has not applied to my office for a categorical grant. What I have tried to do, in St. Louis, MO—which is right across the river—Dr. Bill Harvey has a program and many people in East St. Louis go to that program.

The other problem is that East St. Louis has had some problem with the State government—the city itself, as you very well know—and it's up to them to make sure that any grant or any request from your town is forwarded to my office. That has not been forthcoming. That's why I've turned to St. Louis, MO, to one of my colleagues, who I know has helped the town because you do have a significant problem, and the town is 97-98 percent black.

So I have a great deal of empathy and sympathy for what's happening. If Congress, this year, authorizes my office to fund directly those programs that merit funding in your town, I won't have to go through the State. We can do it on a direct basis.

Dr. **Johnson**. In terms of the programs supported by the Office for Substance Abuse Prevention, OSAP, those programs do not go through State government; they go directly to the community-based organization or whoever is the particular applicant for the funds. We provide an enormous amount of technical assistance to potential applicants, such as holding workshops and conferences, to help them apply for funding.

Therefore, if you're interested in any of the programs that I mentioned, such as the High-Risk Youth and the Pregnant and Postpartum Women and Infants Programs, and a third program, which is really our largest, the Community Partnership Program, you can request grant application. Our Community Partnership Program helps a particular community develop a comprehensive approach to their substance abuse problems which is what has been talked about during the panel presentations.

Those types of grants are funded directly to the community-based organization. I'd be very pleased that East St. Louis might want to apply for funding. I don't know offhand what funding we have in East St. Louis, but I'd be very happy to provide that information to you.

If you want to contact us regarding that kind of information or to receive an application, just call 1-800 and use the words "say no to," they translate into numbers. That's our national clearinghouse for alcohol and drug information. From there they then distribute the grant applications.

And, you can also contact us or contact that number for someone to help you apply for grant funding.

Mr. ARTHUR JOHNSON. OK, thank you.

Mr. RANGEL. Dr. Johnson has to leave. We appreciate the time that she spent with us and we also thank you for advising us ahead of time. We look forward to working with you to pull together the national 1-day conference that will be small enough so that this room can accommodate it.

Dr. JOHNSON. I really do appreciate that, and particularly in relationship to business and industry, the Community Partnership Program I just described has the component for business and industry to be a part of it. So we have a good number of people for such a meeting.

Mr. RANGEL. That's good because there's no sense reinventing the wheel. It could very well be that once we bring the people together, we'll know more specifically the type of help that we need.

Dr. JOHNSON. Thank you.

Mr. RANGEL. Yes, ma'am.

Ms. HELEN NORMAN. Yes, my name is Helen Norman. I'm working with the Research Triangle Institute on a feasibility study that is funded by the National Institute on Drug Abuse.

Some of the issues that were brought up today, our feasibility study is looking at direct services and using research in a manner to look at people and the direct services.

I have a suggestion. One of the things we found is that the same people who are in drug treatment receive public welfare assistance. Their children are in public schools. They receive public health care. They use public transportation.

I was happy to hear that the different disciplines are going to come together to talk about these issues. But I'd like to suggest that prior to your roundtable forum, that you form focus groups—focus groups that can talk about the issues, talk about some solutions, so that when you come to the table, you come with some solutions that have been discussed, and that you invite the practitioners and the researchers.

We have some information and I brought with me a preliminary report of our feasibility study. It is a 2-year study and we're 8 months into it, but we do have some preliminary information that I think this panel might be very interested in looking at.

That's really all I had to say.

I would like to talk with all of you in more detail about the study that we're doing. One of the things I found with some of the research projects is they end at the end of the study. We're taking it a step further in that we're publishing, and I'm one of the authors, of a "how to" manual, how to enhance treatment, how to form coalitions within the community that will address education, health care, treatment, housing.

I hope that I could be of assistance to your panel in providing you with some of that information.

Mr. **Rangel**. That's great. Let me promise you two things. First of all, I assure you that if you send the material to our office, we will see that it's distributed to this panel. And if you provide a summary of it, I will enter it into the Congressional Record and have it produced singularly so that we will make certain that the conference would have this.

And whatever suggestion you or others may have as to what we should be doing, please feel free to write me directly and share that with me. Mark it "Personal" so that it comes directly to my attention and bypasses staff.

Ms. **Helen Norman**. Thank you.

Mr. **Rangel**. Yes, sir?

Mr. **Douglas Williams**. Mr. Chairman, and to the members assembled around you for resource, I'm Douglas Williams. I'm in central Florida presently, having attended the caucus in its 11th and 12th year—I go back those few years with the caucus—and having been away, I'm returning, as I'm sure some others are now. I see and hear a lot of resources before me today.

I'm presently working with some physicians in central Florida and what we're doing is we're trying to link the public health care in Orange County in connection with the Medicaid Administration and the private physicians to deliver the babies of the children of those persons who are now called medically indigent.

In conjunction, we are trying to establish a family planning division to those birthing centers and, of course, some prenatal care services.

I have discovered that the crisis of this has caused us to run into problems with going the normal route to secure the kind of access. So my interest is, because we are interested, we are interested in opening birthing facilities that can in turn deal with not just the delivery of children but while you have those mothers who come out of those kinds of housing areas who are Medicaid patients, while you have access to them you then, in turn, of course, have access to their children. Because we're finding that a large number of these mothers are second- and third-time bearers of children.

Our interest, of course, is to help them in having healthy babies. But in conjunction with that, we are touching their families. We are trying to identify——

Mr. **Rangel**. We are trying to limit this section to questions.

Mr. **Douglas Williams**. Sure.

Mr. **Rangel**. With the understanding that if there are programs that you would want us to assist in getting to the proper agencies, then please write and send them in. But we really want to take advantage of this panel to answer questions.

Mr. **Douglas Williams**. What the gentleman had raised in terms of the one-stop facility, I don't know how we could connect the center with that—the two could be one. I don't know. I surely would like to talk with him.

And, second, I'd like to be involved in their working session where there would be more time, of course—the session that you're pulling together—and how can you get in on that, and how can the center that he's talking about be a part of what we're doing?

Dr. PRIMM. Let me interrupt you.

Central Florida is a vast area. Could you pinpoint the town that you're talking about?

Mr. DOUGLAS WILLIAMS. Orlando.

Dr. PRIMM. Orlando? OK.

We would be glad to talk to you. My able deputy is sitting right behind me—Ms. Lisa Scheckel—and we can tell you how to try to get some connection between services in Orlando so that you can, if you don't have it in one-stop shopping, you can have those supermarket services by marrying many other services—and we can almost tell you how that can be done.

Mr. RANGEL. Thanks for sharing with us your program, because it allows me to tell others in the audience that if you're involved on the frontline with any program that you would believe could make a contribution to the conference, please send that in to us and we will evaluate that as well.

Thank you so much, sir.

Mr. DOUGLAS WILLIAMS. Thank you.

Mr. RANGEL. Yes, sir.

Mr. JOE PENNY. How are you doing, Mr. Chairman? My name is Joe Penny. I've heard a lot of good things today, I really have.

Me, myself, I'm a recovering addict. I've been to three drug rehabs and two psychiatric wards in my life. I'm 21 years old and I'm still a child.

One thing I noticed that's been lacking is the utilization of addicts that have come out of the drug rehabs. For instance, I have come out of drug rehabs that had a lot to give back. But then I'd go into a lab drug rehab and say, "Look, I want to give something." Oh, well, you don't have a degree, you don't this, you don't have that, so, therefore, you can't do anything.

But I have learned more than a lot of people will ever learn in school. I've learned the pain. I've learned the way of thinking. I've learned the rationalizations that you learn that drug addiction gives you. I've learned how the mind works.

I think maybe that there should be more organizations or more groups that should learn to utilize the addicts that come out of drug rehab and maybe that might cut the costs, too, instead of getting these big guys that have been in school for 8, 9 years that learn a lot of book knowledge. But I know for me when I was in there listening to people tell me and tell me how addiction is and what it does, but yet, they've never smoked a joint or they've never done any cocaine—I don't really want to hear it because they don't know how it feels. And you have to pay these people all kinds of money.

But I think maybe if you utilized the addicts that come out and really know what's going on and really know the emotions, you really won't have to pay them as much, and I think that would cut a lot of cost.

Mr. RANGEL. Dr. Primm.

Dr. **Primm**. Let me say that the very backbone of community-based organizations of drug treatment is the recovering addict population—throughout every city in the United States they are used. As a matter of fact, before professionals began to get involved in addiction, that's all we had. They were the people who carried the banner for the rehabilitation of addicts.

The other thing that's important here, though, is that along with that experience that you had from your addictive behavior, you now need some education that you could get while at the same time you are volunteering or are employed in an addiction treatment program.

We've made that kind of thing available in treatment programs, where people who are recovering persons, go to work and become professionally trained while they are working so that they can be able to document adequately and accurately whatever is required to be compliant with State and Federal regulations.

Mr. **Joe Penny**. OK. Maybe my question is: First, where could I look? And, second, I can name——

Dr. **Primm**. I don't know where you come from. Where's your home town?

Mr. **Joe Penny**. I'm from Washington, DC.

I can name three——

Dr. **Primm**. There's WACADA here. There's the Alcohol and Drug Abuse Administration here in Washington, DC that you could also apply to. There's COBA Associates here in Washington, DC. There are any number of organizations that——

Mr. **Joe Penny**. OK. I will make this real fast. If you look at Dominion, if you look at PI [Psychiatric Institute], if you look at several other drug rehabs that are in here, they won't do that. I'm just making a point that those are some, and maybe they should be looked at because those are large drug rehabs and they are going up, but they're spending a lot of money and doing a lot of things with taxpayers' money going nowhere.

Mr. **Rangel**. What about RAP? I know that a lot of recovering addicts work for RAP.

Dr. **Primm**. Absolutely.

Mr. **Rangel**. Why don't you send a note to Congresswoman Holmes and courtesy copy me and I'll follow through personally on that.

Dr. **Primm**. He could also send them out so I can give him a list of all the——

Mr. **Rangel**. Yes, very good.

Yes, ma'am.

I'm Dr. Winifred Duncan. I'm from your assembly district in New York. I just wanted to address something to the young man that just spoke.

As you know, we have a large program in New York and it's throughout the city. We are opened up for the addict to be educated because they need guidance. We have plenty of programs in New York. We have plenty of programs. And there are plenty here in Washington, because basically this is my home.

When I hear a young man open his heart up to us like this, it kind of hurts. I've been in the field for 19 years, as you know, Congressman Rangel, and it is really, really hard to watch a young man want to do something and he doesn't have the right avenue or right tools to use.

Today I brought with me Professor Crumpler. She's a supervisor of social work in alcohol and drugs. She would also like to enlighten some of the things that happened at our hospital.

Mr. RANGEL. OK, but this section of the program, however, is for questions. The record will remain open for the sharing of any ideas or programs or modalities that we have. But we are about to wrap it up, so if you have a specific question, I wish you would frame it.

Ms. WINIFRED DUNCAN. I'll go see you later.

Mr. RANGEL. Very good.

Yes, sir.

Mr. WAYNE UPTON. My name is Wayne Upton. I'm a social worker for the District of Columbia Government. I work right next to an open air drug market at 7th and H Streets, and I sometimes see the drug trafficking there.

I'm also aware that there are some people who are social workers for the District of Columbia Government who are former school teachers because they got burnt out being school teachers.

My overall comment—and I'm also an adult child of an alcoholic. My father quit drinking at 23 when he started going to AA meetings, but he didn't quit smoking until about 7 years later, and he was at two packs a day. And this time, 4 years ago, before he died, he was on the supportable oxygen.

The thing that really stands out—because I remember the late Julius Hobson in dealing with the problem of the schools, is that we need to focus on not only attitudes—someone's attitudes is more important than funding.

My feeling in listening to this is that we need to focus on the attitudes of the middle and upper classes; attitudes about legal drugs such as cigarettes and alcohol because no person here, when they talked about treatment—because there are now many 12-step programs for adult children of alcoholics; no one has mentioned the 12-step programs.

I think until society's overall attitude about smoking and alcohol changes, maybe we're not going to be very effective in dealing with the illegal drugs. And until we focus on how to change overall attitudes—we need to focus on attitudes just as much as we need to focus on funding. I think we're focusing too much on funding and not enough on changing of attitudes. And nobody has mentioned how 12-step programs can treat people, because a person here in DC—even in Anacostia, even in Southeast Washington—can go to three and four AA meetings or NA meetings a day, whereas, 15 to 20 years ago, it was maybe much more difficult.

Mr. RANGEL. Let me thank you for your contribution. There's no question about the accuracy of your statement but, again, I want to emphasize that this area is just to ask us a question. Unfortunately, the Select Narcotics Committee was restricted to illicit and illegal drugs but there is no question in my mind that addiction is addiction and that behavior patterns have to be broken if we're going to have a healthy America.

I thank you for your contribution and we are going before the legislature to see whether our mandate can be expanded, but politically speaking, there are turf problems that we have—so we're restricted in the areas that we can take testimony.

You will see Mr. Goodfriend circulating or we will have pads at the tables—pads and pencils—so that before you leave, you can leave your name and organization and address so that we can inform you as to the follow-through that will take place as a result of the discussion this morning.

Yes, ma'am.

Ms. **Shirley Jackson**. I'm Dr. Shirley Jackson from the U.S. Department of Education, Office of Education, Research, and Improvement. Our assistant secretary is very concerned about this issue and has asked me to track down what is going on. So I've pulled together a lot of information and talked to a lot of people, have been on the road, and intend to get back on the road again.

In December, we'll be meeting with the Urban Superintendents Network, and my question is, from the panelists: What do you think are the two most important things that we need to tell urban superintendents about this problem when we meet with them this fall?

Thank you.

Mr. **Rangel**. Don't walk away because you've just committed yourself to being a part of this conference. And, again, because you are meeting with these urban superintendents, it means that we don't have to meet with urban superintendents. And it means that when you participate, you will be telling us and the Administration and the legislators, and those of us that want to develop a strategy, what these urban superintendents have told you.

In other words, I don't want to beg the question, but they're on the front line. I would say that you should tell them that you have agreed to participate with a group of educators, doctors, people in politics, people out of politics, superintendents, private sector people, to present some program with mayors, Governors, and the Administration to see whether we can formulate a policy, and with the people from OMB—so that we can direct our resources and attention of preventing and correcting a problem that could be of benefit to our national security.

I don't want to opt any of the panelists, but that's what I hope you would be able to tell them, that you are going to be a part of this team to try to weave the strategy together.

Dr. **Knight**. I think I would also add that this is a very critical problem, and there is a reluctance on the part of superintendents to own this problem at this point.

I think in addition to that, I would be sure to have some data, because it is perceived that this is strictly a black problem. We have a lot of black youngsters who are exposed and they are identified because they are in the system. But there are a number of children who are outside of the system that are not identified that we still have to deal with in public schools.

And perhaps letting them know that this is not a black problem; that this is a problem that all Americans will have to and should own, if we don't own it now.

Dr. **Davis**. I have to agree with that, and I don't think we can emphasize it enough. There have been some landmark studies to show that blacks get reported almost 10 times as frequently as nonblacks in terms of drug use during pregnancy.

It goes without saying that we're talking about something that affects the brain and pays no attention to the race or the class of the individual.

Certainly, youngsters who are coming from nonminority families have the opportunity to go to wonderful preschool programs; they have families that are not torn asunder as much as we minorities do; and they really have a head start on the game.

On the other hand, I think we have to say that many of those youngsters, in spite of all the good things that they have going for them, are going to present with similar problems. They will simply be identified as having something else wrong with them.

But in addition to that, I think we have to let the superintendents know, first, that the problem is larger than anyone believes because most of it goes undetected. And, second, that we're not dealing with a lost generation if we look at the entire group of youngsters exposed to drugs.

But that in order to say that, we have to say that some early intervention is necessary. I really do believe that if we don't begin to work with these youngsters very early on, that if we wait until they're age 5 and into school, we may very well have missed the boat if we think traditional models of teaching are going to work. You just cannot throw the majority of these youngsters into a class of 30 youngsters, with one teacher, without additional support, and expect this to be a nonlost generation.

Dr. **Primm**. Could I just comment, Dr. Jackson, it was?

Ms. **Shirley Jackson**. Yes, Shirley Jackson.

Dr. **Primm**. When I came to Government, I can remember—or when I used to come to each one of the caucus meetings, and I've been to about 18 of them—Congressman Rangel used to talk about the lack of communication between departments of Government who had moneys to do things in drug abuse.

I listened to you, and you've been sent out by, I guess, Mr. Alexander, to find out what's going on here.

HUD, Labor, HHS, Justice, and now, I hope, the Department of Education, should all be working together. When I came to my office, I said that anybody who is working in Government that had anything to do with treatment, ought to be meeting on an intra- or interdepartmental basis to coordinate efforts.

I'm happy to see that you are here. You may have heard me mention our coordinated effort with HUD. We have a coordinated effort with the Department of Labor where the Job Corps now will have drug treatment provided by my office; and training of people in the Job Corps to recognize early drug use. We need that same thing in the Department of Education. With a willingness on the part of the Secretary of Education and, of course, by you being here, I'm very happy to hear that. And I'm sure the chairman is elated.

Ms. **Shirley Jackson**. Let me say that there has been a coordinated effort with the Department of Education and HHS, and NIDA. They are in the process of developing—they've already let a contract—to develop a technical assistance package where they are going to identify where the sites are that appear to be working, and do some video taping, as well as a handbook for administrators and teachers.

This is aimed particularly at school people to say when these kids hit your doorsteps, this is what we know now—this is incomplete information, but this is what we know now about what you can do to help them. These are the places—such as in Tampa, FL, such as in Los Angeles; and the places such as Diane's Project DAISY, where they are doing these kinds of things.

So there is a collaboration that is going on with those agencies.

What I'm trying to do right now and in working through that is to get in front of some of the press that seems to be saying that it's a hopeless situation; that these babies, these children need to be labeled and kind of shuttled off into little places; and to let the urban superintendents know what it is that we know in a positive way so that these children are given a chance, not to be segregated and put into places where they're not given the academic stimulation that they need.

Mr. Rangel. Doctor, do you know Assistant Secretary Robert Davila?

Ms. Shirley Jackson. Yes, in OSERS.

Mr. Rangel. What is OSERS?

Ms. Shirley Jackson. Office of Special Education and Rehabilitative Services.

Yes, his office is working with that as well.

Mr. Rangel. They are not ahead of the curve.

Ms. Shirley Jackson. No comment.

Mr. Rangel. So I think what we should do before we reach out to the private sector and local and State governments, Dr. Primm, is that we're going to have to have our own Federal little mini conference here to be better prepared to share with the others what we think we're doing.

But I think we have blinders on because in your Department we're not fully aware. I mean, with all the testimony that we took from Robert Davila, we never heard of your office—that really is what we were searching for.

So you tell the urban superintendents that you hope that they could organize and give you the name of someone that they would want to represent their agenda at this conference.

When's the meeting?

Ms. Shirley Jackson. We're in the process of scheduling for sometime in December.

Mr. Rangel. I'd be glad to participate in the program or to send staff down there, or to do whatever we can do. And one thing that you've just done is to make a commitment, and I've got staff reaching out to you to make certain that you don't get away.

Thank you for your contribution.

Yes, ma'am.

Ms. Valyncia Hinson. Are there any proposals or any findings or any kinds of models to teach this generation of crack babies?

Dr. Powell. In terms of model programs, there are quite a few programs that are operating. There's a Sabin School in Los Angeles that has done some work. Our project, Project DAISY here, is in the process of developing strategies in Florida—Linda Delapenha, who is working out in Hillsboro County, has come up with very specific training strategies for teachers. There are quite a few things that are being looked at now.

One of the things that we're finding is that the body of knowledge is a growing body of knowledge and it changes based on the differences that our children are presenting.

But as Dr. Jackson indicated, when she pools together this group, we're going to be bringing together a lot of that information so that it can be shared more centrally and that there will be a dissemination location to get information about the programs that are existing right now.

Dr. **Knight**. There are a number of programs, but in terms of the experts developing or designing a "curriculum" at this point, the process is going on.

However, there are some strategies that we have used that are extremely successful. High scope is a strategy that we used in California that is extremely successful. And, of course, we use many of the early childhood education principles that are sound to assist us in designing a program in the interim.

Be very careful, however, that as you look at your program, that you are able to at least distinguish between programs that are set up for special ed youngsters and these youngsters. Now, the Sabin Program is a program in Los Angeles where the youngsters were placed in a special ed model.

Our position on that is that the special ed model is not necessarily a successful model and, therefore, it would certainly not be appropriate to place these youngsters automatically in special ed. As a matter of fact, our program, the Parent-Child Intervention Center, located in East Palo Alto in the Ravenswood school district, built our own program because of the fact that we felt that it was a disservice to dump youngsters in special ed primarily because they were identified as youngsters who had been prenatally exposed to drugs.

And our data shows that over 90 percent of these youngsters have average or above average intelligence. The problem with these youngsters was behavioral in nature. In public schools there's a tendency to refer youngsters who have behavioral problems to special ed. As a consequence, a number of these youngsters were being assigned to those classes.

So I would suggest to you that as you observe these programs, that you have them give you a comprehensive description so that you will know that this program would be the kind that might be appropriate for any youngsters that you may decide to establish programs for or provide some assistance to.

Dr. **Primm**. Could I make a comment here?—and it's just an observation.

You might have noticed that Dr. Knight, when she referred to youngsters that were exposed in utero to drugs, spoke of them as youngsters exposed to drugs, and not crack babies.

Let me tell you about the indelible stigmatization that takes place when we begin to say a "crack baby," which has a negative connotation, and follows that child throughout his or her learning career.

My first degree was a bachelor of science in education, and in case I didn't get into medical school, I was going to teach. The whole thing was, when kids were in remedial education, they were stigmatized. Now we talk about programs for exceptional children. We don't talk about negative reinforcement which will cause someone to perform in a particular fashion.

I would like to suggest that the audience and other members of the panel, anyone who talks about drug-exposed infants, talks about them in that light.

Ms. VALYNCIA HINSON. I understand that, but for the sake of time, I wanted to just keep it short. Thank you.

Mr. RANGEL. Make certain your name is down there because one of the things that we wanted to come out of this mini conference is to see whether we can get a national strategy to have more resources out there to better train teachers and professionals.

Thank you so much.

Ms. VALYNCIA HINSON. Thank you.

Mr. RANGEL. I can't thank you enough for attending, and thanking Dr. Jackson for volunteering—that's the way we get volunteers in my home town.

It's going to be exciting as to what comes out of this, because the tragedy of this whole hearing is the limited amount of people that at least know what the problem's all about.

I think that when we bring together what we're trying to do about it and how we can get a better handle on it, that this could be the national role model.

So we'll be bringing the policymakers, the private sector, the professionals, together. And I can't tell you how good I feel, and members of the Congressional Black Caucus, that we just didn't listen to each other and feel good about what we're trying to do, but we're going to carry through so that at our next conference we'll be able to report to you in a positive way what has come out of this.

I want to thank Dr. Beny Primm, who has credibility in and out of the Administration, who can support the efforts that will be coming as a result of this panel discussion; and certainly our outstanding panelists for not only coming on this weekend but for initiating and whetting our appetite for what has to be done as a result of the excellent testimony that was given to the Select Narcotics Committee not too long ago.

Mr. RANGEL. Thank you for your attendance and participation.

Dr. PRIMM. Thank you very much, Mr. Rangel.

Mr. RANGEL. The Select Narcotics Committee hearing stands adjourned.

[Whereupon, at 12:35 p.m., the select committee was adjourned.]

APPENDIX

Jim Ramstad

OPENING STATEMENT BY CONGRESSMAN JIM RAMSTAD
HEARING ON "DRUG-EXPOSED KIDS: A CRISIS IN AMERICA'S SCHOOLS"
HOUSE SELECT COMMITTEE ON NARCOTICS
SEPTEMBER 13, 1991

Mr. Chairman, I would like to commend you for holding this second hearing on the horrible impact that drugs are having on our children. This has been an issue of tremendous importance to me ever since my days as a state senator back in Minnesota, and I appreciate this opportunity to receive testimony from today's panel of experts.

Mr. Chairman, all across our nation, more and more students are experiencing behavioral disabilities that disrupt classes and prevent students from learning. In thousands of cases, these problems are due to children who have been exposed to drugs either prenatally or perinatally.

And the problem is only growing worse. As the use of illegal drugs spreads through our neighborhoods, schoolyards, and playgrounds, an increasing number of children are born addicted to drugs. Those who have tried to abstain from an addictive substance know the pain of going "cold turkey." Can anyone imagine having to undergo such trauma upon birth?

I have witnessed firsthand the tragic effect that drugs have had on babies. I have held these tiny children--fighting for their very lives--in my hands, and I have seen firsthand the suffering in their eyes. We must do everything in our power to end this national tragedy.

As a member of this Select Committee and as the new Chairman of the House Republican Study Committee on Illegal Drugs, I will make it my top priority to help find a solution to this tragic problem. I look forward to hearing from today's witnesses and using their knowledge to ensure that America's children will not be handicapped by illegal drugs, before or after birth.

Thank you again, Mr. Chairman, for convening this hearing and for your leadership in this critical area.